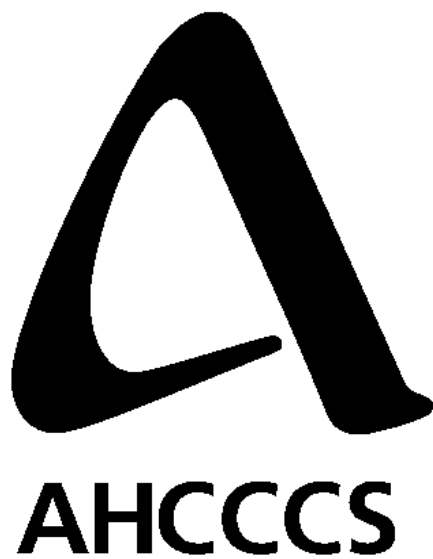


AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE
2005 - 2006





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AGENCY CONTACT

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GLOSSARY

Arizona Administrative Code: Commonly referred to as “rules” these are the state regulations established pursuant to relevant statutes. The rules governing AHCCCS behavioral health services are found in R9-22, Article 12, for acute care; R9-28, Article 11, for Arizona Long Term Care System, (ALTCS); and R9-31, Article 12, for KidsCare. The rules governing licensing of behavioral health agencies are at R9-20.

Bed Holds: A bed hold is a twenty-four (24) hour per day unit of service that is pre-authorized and which may be billed despite the member’s absence from the facility. Title XIX reimbursement for a reserved bed is allowable to a nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or in a Residential Treatment Center. For persons age **21 and older** in ICF/MRs or nursing facilities, the therapeutic leave days (to visit family or friends, to prepare for discharge to community living, etc.) are limited to 9, and bed hold days (for an admission to an acute and/or psychiatric hospital), are limited to 12 days per year. For individuals **under 21 years** of age, Title XIX/Title XXI reimbursement for **a total of 21 days** in any combination of therapeutic leave and/or bed hold days is allowable. Payment for days in excess of these limits, within a July 1 – June 30 contract year, may be covered at the contractor’s discretion with **non**-Title XIX/Title XXI funds.

Behavioral Health Evaluation (R9-22-112): means the assessment of a member’s medical, psychological, psychiatric, and social condition to determine if a behavioral health disorder exists and if so, to establish a treatment plan for all medically necessary services.

Behavioral Health Medical Practitioner (R9-20-101): is a physician, physician assistant or nurse practitioner with one year of full-time behavioral health experience. Behavioral health licensure rules include this level of practitioner as a **behavioral health professional**. AHCCCS grants Category of Service (COS) 47 (Mental Health) to behavioral health medical practitioners who, upon request to Provider Registration attest that they have the requisite behavioral health experience.

Behavioral Health Independent Biller: AHCCCS registered providers who are qualified to bill COS-47 codes, including behavioral health medical practitioners, psychologists, and Independent Master’s Level Therapists, (see definition for Independent Master’s Level Therapists).

Behavioral Health Professional: (R9-20-101)

- A) **Arizona Licensed:** A licensed psychologist, a registered nurse with at least one year of full-time behavioral health work experience, or a behavioral health medical practitioner, or
- B) **Arizona Licensed:** A social worker, counselor, marriage and family therapist or substance abuse counselor licensed according to A.R.S. Title 32, Chapter 33, or
- C) **Out of State:** An individual who is licensed or certified to practice social work, counseling or marriage and family therapy by a government entity in another state if the individual has documentation of submission of an application for Arizona certification per A.R.S. §Title 32, Chapter 33 and is licensed within one year after submitting the application.

Behavioral Health Recipient: A Title XIX or Title XXI acute care member who is eligible for and is receiving behavioral health services through ADHS and the subcontractors.



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Behavioral Health Services: Behavioral health services include evaluation and treatment and support services for both mental disorders and substance abuse.

Independent Master's Level Therapists: Masters level behavioral health professionals who are licensed by the Arizona Board of Behavioral Health Examiners as a Licensed Clinical Social Worker (LCSW); Licensed Professional Counselor (LPC); Licensed Marriage and Family Therapist (LMFT), or Licensed Independent Substance Abuse Counselor (LISAC). The scope of practice for LISAC includes evaluation and treatment of substance abuse disorders.

Inpatient Psychiatric Facility: *Inpatient psychiatric facilities are non-hospital facilities which provide the Medicaid inpatient benefit to eligible individuals.* These facilities include Level I residential treatment centers (provider types 78, B1, B2 and B3) and Level I sub-acute agencies (provider types B5 and B6). See **Exhibit J** for selected federal regulations applicable to both provider categories. Note that the accreditation requirements for Level I residential treatment centers and sub-acute facilities require accreditation by the Council on Accreditation (COA), The Rehabilitation Accreditation Commission, known as CARF, or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

School Based Claiming Program: AHCCCS provides Medicaid coverage of certain services rendered by providers who are employed by, or contracted with, the Title XIX member's Local Education Agency (LEA). LEAs include public school districts, charter schools not sponsored by a school district and the State School for the Deaf and Blind. Services are covered only for AHCCCS Title XIX members who are at least 3 years of age but younger than age 22 and who have been determined by the LEA to be eligible for special education and related services. KidsCare members and SOBRA family planning members are not eligible for services through the Medicaid in the Public Schools Program. For more information see the AHCCCS Medical Policy Manual, Chapter 7, <http://www.ahcccs.state.az.us/Regulations/OSPpolicy/>

Rules: See Arizona Administrative Code.



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Eligibility Groups and Delivery Systems

The Arizona Health Care Cost Containment System (AHCCCS) is the state's Medicaid and KidsCare program. The following are the AHCCCS eligibility groups and delivery systems.

TITLE XIX (Medicaid)

AHCCCS covers all mandatory Medicaid groups and several optional Medicaid groups. All Title XIX members have comprehensive behavioral health benefits. (See **Covered Services** section.)

Title XIX members may be enrolled in:

Acute Care Health Plans: Comprehensive acute care medical services are provided through contracted health plans using a managed care model. Behavioral health services for acute care Title XIX members are 'carved out' and are delivered through Regional Behavioral Health Authorities (RBHAs). By statute, AHCCCS contracts with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), which sub-contracts with the RBHAs for provision of these services. For children in CPS custody (foster children), the Arizona Department of Economic Security provides comprehensive medical services through the Comprehensive Medical and Dental Plan (CMDP) statewide. See **Exhibit A** for a map of Health Plans/RBHAs and their geographical service areas. See **Exhibit D** for health plan phone numbers.

Indian Health Services (acute care): Native American AHCCCS members have the option to select either the Indian Health Service (IHS) or an AHCCCS contracted health plan located off-reservation for Medicaid acute services. If the member chooses IHS, all available services are provided by IHS. If a Medicaid covered service is not available through IHS the member may obtain services on a fee-for-service basis authorized by the AHCCCS Administration. A member who has chosen IHS is not 'locked-in' and may change to an AHCCCS health plan at any time. These members may elect to receive their behavioral health services through a tribal RBHA (TRBHA), if available, a Tribal 638 Facility or a RBHA. See **Exhibit I** for a listing of Indian Health Services phone numbers.

Arizona Long Term Care Services (ALTCS): All ALTCS members are Title XIX and enrolled with ALTCS Program Contractors. Services for Elderly and Physically Disabled (EPD) and Developmentally Disabled (DD) members who qualify for the ALTCS program are delivered by a network of program contractors located throughout the state. See **Exhibit B** for a map of EPD Program Contractors and their geographical services areas. See **Exhibit E** for a



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Eligibility Groups and Delivery Systems

listing of phone numbers for ALTCS Program Contractors. Program contractors for EPD members provide medical services, Home and Community Based Services (HCBS), case management and behavioral health services. Behavioral health services are ‘carved in’ and ALTCS program contractors contract with licensed behavioral health professionals and/or agencies to provide services.

By statute, ALTCS services for the developmentally disabled population are delivered by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES/DDD contractors provide medical services, HCBS, case management and behavioral health services. DES/DDD has an Intergovernmental Agreement (IGA) with ADHS/DBHS to have comprehensive Title XIX behavioral health services for their members provided by the RBHAs in each area of the state. See **Exhibit H** for a listing of RBHAs by county. See **Exhibit C** for a map showing DES/DD contracted health plans by county, and see **Exhibit F** for phone numbers of DES/DDD contracted Health Plans.

Indian Health Service (ALTCS): Tribes may enter into an Inter-governmental agreement with AHCCCS for case management services for Tribal members who are ALTCS eligible. The Tribe is then responsible to ensure the member receives all medically necessary ALTCS services, including behavioral health services, regardless of whether the member resides on-reservation or off-reservation. Tribes are paid on a capitated basis for case management but all other services are paid on a Fee-For-Service basis by AHCCCS. See **Exhibit G** for a listing of Tribal Contractor telephone numbers.

TITLE XXI (KidsCare)

KidsCare is Arizona’s version of the State Children’s Health Insurance Program (SCHIP) federally funded through Title XXI of the Social Security Act. AHCCCS KidsCare offices process and determine eligibility for children ages 0 up to their 19th birthday. At the time of application, the child or parent selects an entity to provide the health care from either:

AHCCCS acute care health plans – includes comprehensive behavioral health benefits within limitations of the program, and provided through RBHAs.

Indian Health Service and 638 Tribal facilities for Native American enrollees
- includes comprehensive behavioral health benefits within limitations of the program and provided through a TRBHA, if available, a Tribal 638 Facility or a RBHA.



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Eligibility Groups and Delivery Systems

OTHER ELIGIBILITY GROUPS

Family Planning Services Program

Women who lose SOBRA eligibility 60 days after the end of pregnancy may be eligible for family planning services *only* up to 24 months postpartum through their AHCCCS health plan. The health plan is not responsible for provision of any other services, including behavioral health services. Even though a MediFax (EVS) read out for these members may say *categorical* and indicate health plan enrollment, they do *not* have the 3 day inpatient emergency behavioral health benefit through the health plan as other “categorical” groups do, and therefore should not be referred to health plans for provision of behavioral health services.

Emergency Services Program (ESP)

The AHCCCS Federal Emergency Services Program (FESP) provides emergency health care services on a Fee For Service basis to qualified aliens and non-citizens who are not eligible for full medical service benefits. ESP recipients are not enrolled in health plans and neither health plans nor RBHAs are responsible for providing services to these individuals.



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE Eligibility Groups and Delivery Systems

RESOURCES

Resources that are necessary and useful to contractors, sub-contractors and providers include:

The ADHS/DBHS Covered Behavioral Health Services Guide and its appendices (the ADHS/DBHS Provider Types and Allowable Procedure Codes matrix and the matrix of Fee-For-Service Rates by Procedure Codes.) These documents are available on-line at: <http://www.hs.state.az.us/bhs/covserv.htm>

The ADHS/DBHS Behavioral Health Service Matrix is updated regularly by ADHS/DBHS. For information about these publications contact:

Arizona Department of Health Services
Division of Behavioral Health Services
Policy Office
150 North 18th Avenue
Phoenix, AZ 85007
(602) 364-4660

State statutes which define the services of AHCCCS Administration and Arizona Department of Health Services are in Arizona Revised Statutes, Title 36, Public Health and Safety, and can be found online at:

<http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp>

ARS §36, Chapter 5, et. Seq. (ADHS)
ARS §36, Chapter 29, Article 1 (AHCCCS, Acute)
ARS §36, Chapter 29, Article 2 (Long Term Care)
ARS §36, Chapter 29, Article 4 (KidsCare)

Arizona Administrative Code (A.A.C.) are the official rules of State agencies which define and operationalize statutory mandates. Administrative Rules are published by the Secretary of State and can be found online at: <http://www.azsos.gov/>

A.A.C. R9-20 OBHL licensing rules
A.A.C. R9-21 ADHS SMI Rules (not currently on line)
A.A.C. R9-22 AHCCCS Acute Care Rules
A.A.C. R9-28 AHCCCS ALTCS Rules
A.A.C. R9-31 KidsCare Rules

Medicaid requirements are found in the Code of Federal Regulations, Chapter 42 (42 CFR) and can be found online at: <http://www.cms.hhs.gov/>

The AHCCCS web page, <http://www.ahcccs.state.az.us/site/> includes this document and:



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AHCCCS Medical Policy Manual

<http://www.ahcccs.state.az.us/Regulations/OSPpolicy/>

Encounter Reporting User Manual

<http://www.ahcccs.state.az.us/Publications/GuidesManuals/>

Fee for Service Provider Manual

<http://www.ahcccs.state.az.us/Publications/GuidesManuals/provman/index.asp>

AHCCCS Billing Manual for IHS/Tribal Providers

<http://www.ahcccs.state.az.us/publications/GuidesManuals/IHSmanual/index.asp>

Technical Interface Guidelines (TIG)

<http://www.ahcccs.state.az.us/Publications/GuidesManuals/TIG/preface/prefcont.asp>

Newsletters: Encounter Keys, Claims Clues

http://www.ahcccs.state.az.us/Publications/Newsletters/Enc_keys/Enc_keys04/default.asp

AHCCCS follows the coding standards described in:

UB-92 Manual

International Classification of Diseases, 9th Revision (ICD-9) Manual

Physicians' Current Procedural Terminology (CPT) Manual

HCFA Common Procedure Coding System (HCPCS) Manual

First Data Bank Blue Book for pharmacy information.

VERIFYING AHCCCS ELIGIBILITY AND ENROLLMENT

The Medicaid Electronic Verification System (**MEVS**) uses “swipe card” technology to verify eligibility and AHCCCS enrollment. Plastic recipient identification cards with a magnetically encoded strip enable providers to “swipe” the card through a reader, similar to using credit and debit cards in stores.

For information contact one of the MEVS vendors:

CSA 800-232-2345

Envoy 800-366-5716

The Potomac Group 800-444-4336

The Interactive Voice Response (**IVR**) system allows an unlimited number of verifications by entering information on a touch-tone telephone.

In Maricopa County only, providers can request faxed documentation.

Providers may call IVR at:

Phoenix 602-417-7200

All Others 800-331-5090

The on-line Eligibility Verification System (**EVS**) allows providers to use a PC or terminal to access eligibility and enrollment information.

For information on EVS, contact The Potomac Group: 1-800-444-4336

On weekends, holidays or after regular business hours, contact the AHCCCS Verification Unit:



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Eligibility Groups and Delivery Systems

Phoenix	602 417-7000
All others	800-962-6690

Providers should be prepared to give the operator the following information:

- Provider Identification Number
- Recipient's name, date of birth, and AHCCCS Identification Number or Social Security Number
- Dates of service



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Provider Type	Behavioral Health Provider Types LEVEL 1 PROVIDERS	ALTCS INSTITUTIONAL OR RESIDENTIAL
02	Hospital (May include a distinct behavioral health or detoxification unit within the hospital)	
71	Psychiatric Hospital (IMD)*	Institutional
78	Level I Residential Treatment Center, Secure, non-IMD	Institutional
B1	Level I Residential Treatment Center, Secure, IMD	Institutional
B2	Level I Residential Treatment Center, Non-Secure (non-IMD)	Institutional
B3	Level I Residential Treatment Center, Non-Secure (IMD)	Institutional
B5	Level I Sub-acute Facility (non-IMD)	Institutional
B6	Level I Sub-acute Facility (IMD)	Institutional
B7	Level I Crisis Services	
LEVEL 2 PROVIDERS		
74	Level II Behavioral Health Residential (non-IMD)	Alternative Residential
LEVEL 3 PROVIDERS		
A2	Level III Behavioral Health Residential (non-IMD)	Alternative Residential
OTHER SERVICE PROVIDERS		
A3	Community Service Agency	
A5	Therapeutic Foster Care Home	Alternative Residential
A6	Rural Substance Abuse Transitional Center	Alternative Residential
03	Pharmacy	
04	Laboratory	
06	Emergency Transportation	
28	Non-Emergency Transportation	
39	Habilitation Provider	
72	Regional Behavioral Health Authority (RBHA and Tribal RBHA)	
77	Outpatient Clinic	
INDEPENDENT BILLERS		
08	Physician (Allopathic)	
11	Psychologist	
18	Physician Assistant	
19	Registered Nurse Practitioner	
31	Physician (Osteopathic)	
85	Licensed Clinical Social Worker (LCSW)	
86	Licensed Marriage And Family Therapist (LMFT)	
87	Licensed Professional Counselor (LC)	
A4	Licensed Independent Substance Abuse Counselor (LISAC)	



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COVERED SERVICES

Inpatient Hospital Services
Non-Hospital Inpatient Psychiatric Facility Services
Therapeutic Foster Care Home Services
Community Service Agency
Rural Substance Abuse Transition Agency Services
Behavioral Health Residential Services, Level 2 and Level 3
Outpatient Clinic Services
Screening
Evaluation/Assessment
Individual, Group and/or Family Therapy and Counseling
Psychotropic Medication Adjustment and Monitoring
Partial Care – Supervised Behavioral Health Day Program
Partial Care – Therapeutic Day Program
Partial Care – Medical Day Program
Emergency Behavioral Health Care
Behavior Management – Behavioral Health Personal Care Services
Behavior Management – Family Support/Home-Care Training
Behavior Management – Behavioral Health Self-help Peer Support
Psychosocial Rehabilitation – Living Skills Training
Psychosocial Rehabilitation – Supported Employment Services
Psychosocial Rehabilitation - Health Promotion
Behavioral Health Case Management
Nursing Services
Psychotropic Medication
Laboratory and Radiology Services for Diagnosis and Medication Regulation
Transportation
Opioid Agonist Treatment
Respite Care



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Inpatient Hospital Services

Provider Types:

- General acute care hospital or a distinct unit of a general acute care hospital (provider type 02)
- A mental hospital (provider type 71), an IMD (see IMD Fact Sheet)

Description of Service:

Inpatient hospital services include all behavioral health services, medical detoxification, accommodations and staffing, supplies and equipment to treat episodes of mental illness or substance abuse disorders. Services must be provided under the direction of a physician.

Service Limitations:

1. There are no specific inpatient hospital limitations for Title XIX/XXI members in a **general acute care hospital** (GACH) or a distinct psychiatric unit of a GACH. The 4-day limit for detoxification services was abolished in 1995. Medical necessity determines the length of detoxification treatment.
2. There are specific limitations for Title XIX/XXI members ages 21 through age 64 in **mental hospitals**. For members age 21 through 64, reimbursement for inpatient services in a mental hospital (provider type 71) with more than 16 beds is limited to 30 days per admission and 60 days per contract year (July 1-June 30). An admission which spans contract years, is counted as one admission; only 30 days of the admission are reimbursable with Title XIX/Title XXI funds. After 30 days of an admission or after the 60th cumulative day in a contract year, Title XIX reimbursement is not available for services provided to a member whether the service is in or outside of the IMD, until the member is discharged from the IMD.
3. For Title XIX and XXI members age 20 and younger and age 65 and older, there are no length-of-stay limitations. An individual may not apply for Title XXI (KidsCare) eligibility nor be redetermined for such eligibility while residing in an IMD. A Title XXI member whose annual eligibility redetermination date occurs while the individual is residing in an IMD will be disenrolled from Title XXI and evaluated for Medicaid, Title XIX eligibility.
4. For Title XIX members age 20 and younger who are residing in an IMD (mental hospital), the only Title XIX service which may be reimbursed is the inpatient benefit; Title XIX reimbursement is not available for any other service provided to a member whether the service is in or outside of the IMD, until the member is discharged from the IMD.
5. Prior authorization, with a completed certification of need, must be obtained for planned inpatient hospital services prior to admission.
6. Providers must comply with requirements for utilization control and patient rights in inpatient hospitals. (Exhibit J)
7. Mental Hospitals (provider type 71) must provide written notification upon admission to a Title XIX member or the member's parents or legal guardian:
 - That AHCCCS eligibility for members who are age 21 through 64 may end if they remain in an IMD longer than 30 days per admission or 60 days per contract year (July 1 – June 30);
 - That for members age 0-20, Title XIX reimbursement is not available for any service other than the inpatient benefit (e.g. medical services provided by other than the IMD).
8. Mental Hospitals (provider type 71) are required to notify AHCCCS Member Services (fax: 602-253-4807 or telephone: 602-417-4412) when a Title XIX or TXXI member age 21 through 64 years old has been a resident/inpatient for 30 consecutive days and provide the following information:
 - *Provider* Identification Number and telephone number
 - *Recipient's* name, date of birth, AHCCCS Identification Number *and* Social Security Number
 - Date of Admission

Provider Qualifications:

- Hospitals may provide services to persons if the hospital is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) if providing treatment to clients under the age of 21 and meets the requirements of 42 CFR 440.10 and Part 482 and is licensed pursuant to A.R.S. 36, Chapter 4, Articles 1 and 2;

OR

- Is certified as a provider under Title XVIII of the Social Security Act;

OR

- Is currently determined by ADHS Assurance and Licensure to meet such requirements.
- In addition, hospitals providing emergency inpatient services beyond 72 hours must have OBHL licensure.

- | |
|--|
| <ul style="list-style-type: none">▪ Freestanding psychiatric facilities must meet the specific requirements of A.A.C. R9-20 (i.e., provision of psychiatric acute care).▪ Additionally, if seclusion and restraint is provided, then the facilities must meet the requirements set forth in A.A.C. R9-20. |
| <p>Service Codes:
Revenue Codes 114, 116, 124, 126, 134, 136, 154, 156</p> |



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Non-Hospital Inpatient Psychiatric Facility Services

Provider Types:

- Residential Treatment Center (RTC), (provider type 78, B1, B2, and B3)
- Level 1 Sub-acute facility (provider type B5 and B6)

Description of Service:

Services provided in an Inpatient Psychiatric Facility must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A facility with more than 16 beds is considered an IMD (provider types B1, B3 and B6).

Service Limitations:

1. There are no specific inpatient limitations for Title XIX or Title XXI members in Inpatient Psychiatric Facilities which are not IMDs (provider types 78, B2 and B5 are not IMDs).
2. There are limitations for Title XIX members in Inpatient Psychiatric Facilities which are IMDs, Provider type B1, B3 and B6. (See IMD Fact Sheet)
 - A Title XIX member who is 21 years through 64 years old may receive services in an IMD for up to 30 days per admission and 60 days per contract year (July 1 – June 30). The member remains eligible for other Title XIX covered services during the 30/60 days. However, a member whose stay exceeds 30 days per admission/60 days per contract year may lose Title XIX eligibility.
 - An admission which spans contract years is counted as one admission; only 30 days of the admission are reimbursable with Title XIX/Title XXI funds.
3. There are no length of stay limits (30 days per admission/60 days per contract year) for a Title XIX member under age 21 (EPSDT members) or age 65 and older in IMDs, provider types B1, B3 and B6.
4. For Title XXI members, there are no service limitations. However, an individual may not apply for Title XXI eligibility nor be re-determined for such eligibility while residing in an IMD. A Title XXI KidsCare member whose annual eligibility re-determination date occurs while the individual is residing in an IMD will be disenrolled from KidsCare and evaluated for Medicaid Title XIX eligibility.
4. AHCCCS Contractors must ensure that IMD agencies provide written notification to a Title XIX member or the member's parents or legal guardian at admission that:
 - AHCCCS eligibility for members who are age 21 through 64 may end if they remain in an IMD longer than 30 days per admission or 60 days per contract year (July 1 – June 30). After 30 days, the setting is considered to be an ineligible setting and the member is not entitled to receive any Medicaid service, either inside or outside of the facility, while remaining as a resident.
5. Contractors and providers must comply with requirements for utilization control. (Exhibit J)
6. A Title XIX member who is receiving services in an inpatient psychiatric facility who turns age 21 may continue to receive services (if permitted by facility's license requirements) until the point in time in which services are no longer required or the member turns age 22, whichever comes first. (42 CFR 441.151)
7. Bed holds for Title XIX and Title XXI members under age 21 years in residential treatment centers are covered but must be prior authorized. Bed holds are limited to 21 days per contract year and may be authorized for any combination of therapeutic leave days (home pass, prepare for discharge) and short-term hospitalization.
8. Sub-acute facilities with more than 16 beds (provider type B6 – IMDs) are required to notify AHCCCS Member Services (fax: 602-253-4807 or telephone: 602-417-4412) when a Title XIX or Title XXI member age 21 through 64 years old has been a resident/inpatient for 30 consecutive days and provide the following information:
 - *Provider* Identification Number and telephone number
 - *Recipient's* name, date of birth, AHCCCS Identification Number *and* Social Security Number
 - Date of Admission



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Provider Qualifications:

Non-Hospital Inpatient Psychiatric Facilities must:

- Be licensed and Title XIX certified by ADHS/ALS/OBHL
 - Be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO); the Council on Accreditation (COA); or The Rehabilitation Accreditation Commission, known as CARF.
 - For OBHL licensees authorized to provide seclusion and restraint, meet the federal requirements for seclusion and restraint and utilization controls, Exhibit J.

Service Codes: Revenue Codes 114, 116, 124, 126, 134, 136, 154, 156, 183, 189. Bed Holds are covered in RTCs only, not in sub-acute facilities.



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Therapeutic Foster Care Home Services

Provider Types*:

- DES licensed professional foster care home (provider type A5)
- OBHL licensed adult therapeutic foster home (provider type A5)

Description of Service:

Services are provided in a therapeutic foster care home to a person residing in the home to implement the in-home portion of the person's behavioral health service plan. Services include continuous protective oversight, observation, assistance, or supervision in activities to maintain health, safety, personal care or hygiene, living skills training, and transportation of the member when necessary to participate in activities such as therapy and/or participation in treatment and discharge planning.

Service/Reimbursement Limitations:

1. Therapeutic foster care cannot be billed on the same day as an inpatient revenue code.
2. There is no reimbursement for a 'bed hold' in a therapeutic foster care home.
3. Services are reimbursed on a per diem basis (not inclusive of room and board) and include all services provided by the foster care family/sponsor including non-emergency transportation, family support and over-the-counter medications.
4. Other provider types may provide services on the same day, e.g., day programs, case management, professional services, etc.

Provider Qualifications:

- Child foster care homes must be licensed by the Arizona Department of Economic Security (ADES) as a **professional** foster care home (R6-5-5850).
- Adult therapeutic foster homes must be licensed by the Arizona Department of Health Services, Office of Behavioral Health Licensure (ADHS/OBHL) as an adult therapeutic foster home.
- Prior to authorizing services in the therapeutic foster home, Contractors must ensure that:
 1. The foster care home parents have successfully completed pre-service training in the type of care and services required by the persons being placed into the foster care home;
 2. The foster care home parents have access to crisis intervention and emergency consultation services;
 3. A clinical supervisor has been assigned to oversee the care provided by the therapeutic foster care parents.

Service Codes:

S5140 Foster Care, **Adult** – per diem – **indicate category of service 35 and provider type A5**

S5145 Foster Care, Therapeutic, **Child** – per diem – **indicate category of service 47 and provider type A5**

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information is also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Community Service Agency

Provider Types:

A Community Service Agency (provider type A3) is a provider of non-licensed behavioral health services. Agencies or organizations must be certified by ADHS/DBHS as qualified to provide services for Title XIX and Title XXI members.

Description of Service:

Services which may be provided by Community Service Agencies include Psychosocial Rehabilitation (living skills training, health promotion and pre-job training, education and employment support); behavior management (peer support, family support and behavioral health personal assistance); supervised day programs, respite care and transportation services. Not all CSAs provide all services.

Service /Reimbursement Limitations:

See psychosocial rehabilitation, behavior management, partial care (supervised day program) and respite pages of this document for limitations on specific services.

Provider Qualifications: ADHS/DBHS must certify or attest that each **staff** providing Title XIX/Title XXI services at the Community Services Agency meets established criteria and documentation is available upon request. CSA criteria are found on the ADHS web site, Policy MI 5.2, <http://www.azdhs.gov/bhs/policy.htm>.

For the **agency**, the RBHA must have a copy on file of:

- The agency's incorporation or charter documents, if applicable
 - A current health inspection report, a current fire inspection report and a copy of the Occupancy Permit for each building at which rehabilitation and/or support services will be provided
 - A list of specific services which the agency will provide
 - Provider files for direct services staff or contractors who will provide each rehabilitation and/or support service
- Agency proof of liability insurance covering the staff member or contractor

Service Codes:

H0025 – Health promotion, per 15 minutes
H0034 – Health promotion – medication training, per 15 minutes
H0038 – Community psychiatric supportive treatment, day program, per 15 minutes
H2012 – Supervised behavioral health day treatment, per hour up to 5 hours
H2014 – Group skills training and development, per 15 minutes
H2025 – Ongoing support to maintain employment, per 15 minutes
S5110 – Home care training, family support, per 15 minutes
S5150 – Unskilled respite, per 15 minutes
S5151 – Unskilled respite, per diem
T1019 – Behavioral health personal care services, per 15 minutes
T1020 – Behavioral health personal care services, per diem
Non-emergency transportation codes



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Rural Substance Abuse Transitional Agency Services

Provider Types*:

A rural substance abuse transitional agency (provider type A6) is licensed by ADHS, located in a county with a population of fewer than 500,000 individuals according to the most recent U.S. census, and provides behavioral health services to an individual who is intoxicated or has a substance abuse problem.

Description of Service:

Services to a member in a rural substance abuse transitional agency include an assessment, nursing services, screening, living skills training, health promotion, behavioral health personal assistance, family support, peer support and transportation services.

Service/Reimbursement Limitations:

1. This provider type is not licensed to provide counseling.
2. See psychosocial rehabilitation, behavior management, partial care (supervised day program) and evaluation/screening pages of this document for limitations on specific services.

Provider Qualifications:

Licensure per 9 A.A.C. 20

Service Codes:

Transportation codes

H0002 – Behavioral health screening to determine eligibility for admission to treatment program, 15 minutes

H0025 – Behavioral health prevention education service, 15 minutes

H0031 – Mental health assessment by non-physician, 30 minutes

H0034 – Medication training and support, 15 minutes

H0038 – Self-help/Peer services, 15 minutes

H2014 – Skills training and development, 15 minutes

H2016 – Comprehensive community support services (peer support), per diem

H2017 – Psychosocial rehabilitation living skills training services, 15 minutes

H2025 – Ongoing support to maintain employment, 15 minutes

H2026 – Ongoing support to maintain employment, per diem

H2027 – Psycho educational service (pre-job training and development), 15 minutes

T1002 – RN nursing services, 15 minutes

T1003 – LPN nursing services, 15 minutes

T1019 – Personal care services, 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)

T1020 – Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)

Service Code Modifiers:

HQ – Group setting

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at: http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Behavioral Health Residential Services, Level 2 and Level 3

Provider Types*:

- Level 2 behavioral health residential agency (provider type 74)
- Level 3 behavioral health residential agency (provider type A2)

Description of Service:

Residential services that are provided by a facility licensed per 9 A.A.C. 20. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services (Level 2); or 24 hour supervision and intermittent treatment in a group setting to persons who are determined to be capable of independent functioning but still need some protective oversight (Level 3).

Service/Reimbursement Limitations:

1. Room and board are not Title XIX or Title XXI covered services in Level 2 or Level 3 behavioral health residential facilities.
2. Services are reimbursed via a bundled treatment-day code, which includes services of staff who are not behavioral health independent billers, non-emergency transportation, non-legend drugs and non-customized medical supplies.
3. Support services (case management, family support, peer support) may be billed by providers specifically registered to provide those services.
4. Services provided by a behavioral health independent biller may be billed separately.
5. Psychotropic medication, laboratory and radiology for members may be billed by providers specifically registered to provide those services.
6. H0018 and H0019 cannot be billed on the same day as a respite code.

Provider Qualifications:

Level 2 and 3 behavioral health residential providers must:
Be licensed and Title XIX certified by ADHS/ALS/OBHL

Service Codes:

H0018 Level 2 behavioral health short-term residential (non-hospital residential treatment program), without room and board, per diem
H0019 Level 3 behavioral health long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
S5150 Unskilled respite care, not hospice, per 15 minutes
S5151 Unskilled respite care, not hospice, per diem

Service Code Modifiers:

TF – Intermediate level of care, TG – Complex/high level of care

Modifiers TF and TG are optional. They can be used with the billing code to indicate higher patient acuity and associated rate.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information is also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at: http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Outpatient Clinic Services

Provider Types*: <ul style="list-style-type: none">Outpatient Clinic (provider type 77)
Description of Service: <p>Outpatient clinics may be licensed to provide services such as counseling, medication services, court-ordered evaluation and treatment, and Opioid treatment.</p>
Service/Reimbursement Limitations: <ul style="list-style-type: none">There are no specific limitations for Title XIX/Title XXI members receiving services from an outpatient clinic.Services provided by staff who are not behavioral health independent billers are billed by the agency using HCPCS codes.
Provider Qualifications: <p>Licensure per 9 A.A.C. 20</p>
Service Codes: <p>*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at http://www.hs.state.az.us/bhs/app_b2.pdf</p>



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Screening

Provider Types*:

- Physicians qualified as behavioral health medical practitioners (provider type 08/31)
- Psychologists (provider type 11)
- Physician Assistants affiliated with a psychiatrist or qualified as a behavioral health practitioner (provider type 18)
- Certified Psychiatric Nurse Practitioners or Nurse Practitioners qualified as a behavioral health medical practitioner (provider type 19)
- RBHAs and Tribal RBHAs (provider type 72)
- Outpatient Clinics (provider type 77)
- Licensed Clinical Social Workers (provider type 85) (formerly Certified Independent Social Worker until 7/1/04)
- Licensed Marriage and Family Therapists (provider type 86) (formerly Certified Marriage and Family Therapist until 7/1/04)
- Licensed Professional Counselors (provider type 87) (formerly Certified Professional Counselor until 7/1/04)
- Licensed Independent Substance Abuse Counselors (provider type A4) (New provider type, effective 7/1/04)
- Rural Substance Abuse Transitional Centers (provider type A6)

Description of Service:

Screening is an interaction with the member and a behavioral health professional or behavioral health technician to determine the need for behavioral health services and the assignment of the member for further evaluation, care and treatment. Information may be gathered using a standardized screening tool. Screening service may include the preliminary collection of information necessary to complete a supported employment assessment.

Service/Reimbursement Limitations:

1. For Title XIX and Title XXI members there are no specific limits for screening services.
2. Member transportation is not included in the rate.
3. Provider transportation is included in the rate.

Service Codes:

H0002GT – Screening, 15 minutes

Service Code Modifiers:

GT – Telecommunication

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at

http://www.hs.state.az.us/bhs/app_b2.pdf

Evaluation/Assessment

Provider Types*:

- Physicians qualified as behavioral health medical practitioners (provider type 08/31)
- Psychologists (provider type 11)
- Physician Assistants affiliated with a psychiatrist or qualified as behavioral health practitioner (provider type 18)
- Certified Psychiatric Nurse Practitioners or Nurse Practitioners qualified as behavioral health medical practitioners (provider type 19)
- RBHAs and Tribal RBHAs (provider type 72)
- Outpatient Clinics (provider type 77)
- Licensed Clinical Social Workers (provider type 85)
- Licensed Marriage and Family Therapists (provider type 86)
- Licensed Professional Counselors (provider type 87)
- Licensed Independent Substance Abuse Counselors (provider type A4)
- Rural Substance Abuse Transitional Centers (provider type A6)

Description of Service:

A behavioral health evaluation is an assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and if so, to establish a treatment plan for all medically necessary services.

Service/Reimbursement Limitations:

1. **Medical Practitioners and Psychologists** must always bill CPT (90000) codes.
2. **Outpatient Clinics and Rural Substance Abuse Transition Centers** must always bill HCPCS 'H' codes.
3. **LCSWs, LPCs and LMFTs** should use HCPCS ('H') codes, unless the client also has Medicare and Medicare will be billed as primary insurer.*
4. In that instance, the provider bills Medicare utilizing the CPT code (90801 or 90802), and will submit the EOB with subsequent billing of the same CPT code to the AHCCCS Contractor (ALTCS or RBHA)
5. If the LCSW, LPC or LMFT provides services to a Title XIX member who does not have Medicare, the HCPCS 'H' code should be used.
6. **In no instance may a provider bill for an assessment using both a HCPCS and CPT code.**
7. Evaluations provided in an inpatient setting are included in the per diem rate and cannot be billed separately, except for those provided by behavioral health independent billers.
8. Evaluations may be provided as an outpatient service and billed by outpatient clinics, T/RBHAs, rural substance abuse transition agencies and behavioral health independent billers.
9. Member transportation is not included in the rate.
10. Provider transportation is included in the rate.

*Some ALTCS Contractors have made arrangements with AHCCCS to allow Master's Level Independent Therapists to bill CPT codes regardless of Medicare Status.

Service Codes:

- H0001 – Alcohol and/or drug assessment (PT A4)
- H0031 – Mental health assessment by a non-physician, 30 minutes (PT 72, 77, 85, 86, 87, A4, A6)
- 90801 – Psychiatric diagnostic interview, unit unspecified (PT 08, 11,31, 18, 19, 85, 86, 87)
- 90802 – Interactive psychiatric diagnostic interview using play equipment, language interpreter or other communication mechanisms, unit unspecified (PT 08, 11,31, 18, 19, 85, 86, 87)

Service Code Modifiers:

GT – Telecommunication

Always indicate Place of Service Code



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Evaluation/Assessment Code Table

- **Medical Practitioners and Psychologists** must always bill CPT (90000) codes.
- **Outpatient Clinics and Rural Substance Abuse Transition Centers** must always bill HCPCS 'H' codes.
- **LCSWs, LPCs and LMFTs** should use HCPCS ('H') codes, unless the client also has Medicare and Medicare will be billed as primary insurer.
- In that instance, the provider bills Medicare utilizing the CPT code (90801 or 90802), and will submit the EOB with subsequent billing of the same CPT code to the AHCCCS Contractor (ALTCS or RBHA)
- If the LCSW, LPC or LMFT provides services to a Title XIX member who does not have Medicare, the HCPCS 'H' code should be used.
- **In no instance may a provider bill for an assessment using both a HCPCS and CPT code.**
- Always indicate place of service.

M = Procedure may only be billed by these provider types with EOB from Medicare.

	PROVIDER TYPES						
	08 & 31 Physicians	18 & 19 Physician Assistants & Nurse Practitioners	11 Psychologists	72- 77-A6 RBHAs Outpatient Clinics Rural Substance Abuse	85-86-87 LCSW LMFT LPC		A4 LISAC
CODEs	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX only	Title XIX and Medicare	Title XIX and/or Medicare
H0001							✓
H0031				✓	✓		
90801	✓	✓	✓			M*	
90802	✓	✓	✓			M*	

M* These codes should only be billed by PT 85, 86 and 87 if client has Medicare. Claim may be submitted with EOB to the ALTCS or RBHA AHCCCS Contractor.

AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Individual, Group and/or Family Therapy and Counseling

Provider Types*:

- Physicians qualified as a behavioral health medical practitioner (provider type 08/31)
- Psychologists (provider type 11)
- Certified psychiatric nurse practitioners or nurse practitioners qualified as behavioral health practitioners (provider type 19)
- Physician assistants affiliated with a psychiatrist or qualified as a behavioral health practitioner (provider type 18)
- Independent master's level therapists (provider types 85, 86, 87, A4)
- Outpatient clinics (provider type 77)

Description of Service:

Therapy and counseling services address the therapeutic goals outlined in the Service Plan and are provided by behavioral health professionals and behavioral health technicians. Services may be provided to an individual, a group of persons, a family or multiple families. Family counseling may include, but does not require, the presence of the member.

Service/Reimbursement Limitations:

1. Group and/or Family therapy and counseling services provided in skilled nursing facilities, general acute care hospitals, psychiatric hospitals, residential treatment centers or sub-acute facilities are included in the per diem rate and cannot be billed separately, except those provided by behavioral health independent billers: psychiatrists, psychologists, certified psychiatric nurse practitioners, physician assistants, other behavioral health medical practitioners and independent master's level therapists who may bill separately.
2. Therapy and counseling services may be provided and billed as an outpatient service by outpatient clinics, (provider type 77) and the following independent billers: AHCCCS-registered psychiatrists, psychologists, certified psychiatric nurse practitioners, physician assistants, or independent master's level therapists.
3. Licensed Independent Substance Abuse Counselors' scope of practice is limited to the provision of substance abuse counseling.
4. Behavioral health professionals other than those listed above in Reimbursement Limitation #1, must be affiliated with a licensed behavioral health agency/facility and their services are billed through the agency.
5. Group therapy may be billed for each eligible person in the group.
6. Family therapy is billed once for the entire family.
7. Family therapy/counseling can occur with the client present or absent.
8. Groups cannot be larger than 15 unrelated persons for group therapy, or 20 individuals for family therapy.

Provider Qualifications:

Group and/or Family therapy and counseling services are provided by outpatient clinics whose ADHS/OBHL Licensure Scope of Service specifies *Individual/Group/Family Counseling*; or by licensed Psychologists, behavioral health medical practitioners and independent master's level therapists.

HCPCS Level II Code: Specify POS and modifier as applicable,

H0004 – individual counseling, 15 minute increments

H0004 – individual counseling, out-of-office, specify place of service 12 or 99, 15 minute increments

H0004 - counseling, family, office, specify HR client present or HS client absent and POS 03, 11, 22, 50, 53, 72 minute increments

H0004-HR or HS – family counseling, out-of-office, 15 minute increments

H0004HQ – group counseling, office or other setting, 15 minute increments

Service Code Modifiers:

*GT – Use GT modifier when provided via telecommunication, HQ - Group setting, HR - Family/couple with client present, HS - Family/client without client present

Always indicate Place of Service (POS) (These are listed in the CPT Manual)

Individual, Group and/or Family Therapy and Counseling Code Table

AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

- **Medical Practitioners and Psychologists** must always bill CPT (90000) codes.
- **Outpatient Clinics and Rural Substance Abuse Transition Centers** must always bill HCPCS ‘H’ codes.
- **LCSWs, LPCs and LMFTs** should use the H0004 with modifiers and POS as above, unless the client also has Medicare and Medicare will be billed as primary insurer.
- In that instance, the provider bills Medicare utilizing the appropriate, allowable CPT code, and will submit the EOB with subsequent billing of the same CPT code to the AHCCCS Contractor (ALTCS or RBHA).
- If the LCSW, LPC or LMFT provides services to a Title XIX member who does not have Medicare, H0004 code should be used, or
- If the LCSW, LPC or LMFT is not a Medicare provider, the H0004 may be used.
- **In no instance may a provider bill for counseling/therapy using both a HCPCS and CPT code.**
- Always indicate place of service.

	PROVIDER TYPES						
	08 & 31 Physicians	18 & 19 Physician Assistants & Nurse Practitioners	11 Psychologists	72- 77-A6 RBHAs Outpatient Clinics Rural Substance Abuse	85-86-87 LCSW LMFT LPC		A4 LISAC
CODE	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX only	Title XIX and Medicare	Title XIX and/or Medicare
H0004				✓	✓		✓
90804	✓	✓	✓			M*	
90805	✓	✓					
90806	✓	✓	✓			M*	
90807	✓	✓					
90808	✓	✓	✓			M*	
90809	✓	✓					
90810	✓	✓	✓			M*	
90811	✓	✓					
90812	✓	✓	✓			M*	
90813	✓	✓					

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	PROVIDER TYPES						
	08 & 31 Physicians	18 & 19 Physician Assistants & Nurse Practitioners	11 Psychologists	72- 77-A6 RBHAs Outpatient Clinics Rural Substance Abuse	85-86-87 LCSW LMFT LPC		A4 LISAC
CODE	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX only	Title XIX and Medicare	Title XIX and/or Medicare
90814	✓	✓	✓			M*	
90815	✓	✓					
90816	✓	✓	✓			M**	
90817	✓	✓					
90818	✓	✓	✓			M**	
90819	✓	✓					
90821	✓	✓	✓				
90822	✓	✓					
90823	✓	✓	✓				
90824	✓	✓					
90826	✓	✓	✓				
90827	✓	✓					
90828	✓	✓	✓				
90829	✓	✓					
90845	✓	✓	✓				
90846	✓	✓	✓			M*	

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	PROVIDER TYPES						
	08 & 31 Physicians	18 & 19 Physician Assistants & Nurse Practitioners	11 Psychologists	72- 77-A6 RBHAs Outpatient Clinics Rural Substance Abuse	85-86-87 LCSW LMFT LPC		A4 LISAC
CODE	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX and/or Medicare	Title XIX only	Title XIX and Medicare	Title XIX and/or Medicare
90847	✓	✓	✓			M*	
90849	✓	✓	✓			M*	
90853	✓	✓	✓			M*	
90857	✓	✓	✓			M*	
90875	✓	✓	✓				
90876	✓	✓	✓				
90880	✓	✓	✓				

M* These codes should only be billed by PT 85, 86 and 87 if client has Medicare. Claims may be submitted with an EOB to the ALTCS or RBHA AHCCCS Contractor. If the PT 85, 86 or 87 is not a Medicare provider, use HCPCS 'H' code.

M** 90816 and 90818 are covered inpatient therapy codes. ALTCS providers utilize these codes, primarily in nursing facilities, ADHS/RBHAs do not include these codes on their Matrix.



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Psychotropic Medication Adjustment and Monitoring

Provider Types*:

- Physicians (provider type 08/31)
- Nurse practitioners (provider type 19)
- Physician assistants (provider type 18)

Description of Service:

Psychotropic medication adjustment and monitoring services include prescriptions for psychotropic medications, review of the effects and side effects, and adjustment of the type and dosage of psychotropic medications prescribed that address the therapeutic goals outlined in the service plan.

Service/Reimbursement Limitations:

1. Psychotropic medication adjustment and services are not limited for Title XIX or Title XXI members.
2. Psychotropic medications and adjustments may only be prescribed by a qualified physician, registered nurse practitioner or physician's assistant within their scope of practice. Psychotropic medication monitoring may be performed by a registered nurse.
3. Medication adjustment and monitoring services provided in hospitals and psychiatric hospitals are included in the per diem rate and cannot be billed separately unless provided by a psychiatrist, certified psychiatric nurse practitioner or physician assistant who may bill separately.
4. Psychotropic medication adjustment and monitoring services are not included in the per diem rate of Level I residential treatment centers, sub-acute facilities, Level II or Level III residential facilities and may be billed separately by a provider registered with AHCCCS as a provider of this specific service unless otherwise specified in contract.

Service Codes:

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

PARTIAL CARE

Supervised Behavioral Health Day Program

Provider Types*:

- RBHA (provider type 72)
- Outpatient Clinic (provider type 77)
- Community Service Agency (provider type A3)
(Staff providing this service must be a behavioral health professional, behavioral health technician or paraprofessional)

Description of Service:

A regularly scheduled program of individual, group and/or family activities/services related to the enrolled person's treatment plan designed to improve the ability of the person to function in the community and may include rehabilitative and support services such as living skills training, health promotion, supported employment, peer support and transportation.

Service/Reimbursement Limitations:

1. Day program service codes are mutually exclusive; a provider cannot bill two *different* day program codes for the member on the same day, though up to five units of the same hourly code may be billed.
2. A behavioral health medical practitioner, within the scope of his/her practice may bill CPT codes independently for services provided as part of a supervised day program.
3. For ALTCS members, supervised day program services cannot be billed simultaneously with adult day care services.
4. School attendance and education hours are not included as part of this service and may not be provided simultaneously.

Service Codes:

H2012 - Supervised behavioral health day treatment, per hour, up to 5 hours

H2015 – Comprehensive community support services, supervised day program, 15 minutes, minimum of 6 hours but no more than 10 hours

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

PARTIAL CARE Therapeutic Day Program

Provider Type*:

- Outpatient Clinic (provider type 77)

Description of Service:

A regularly scheduled program of active treatment modalities provided by an outpatient clinic which may include services such as individual, group and/or family therapy, living skills training, health promotion, supported employment, family support, case management and peer support. Services must be provided under the direction of a behavioral health professional.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on therapeutic day program services.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously.
3. Therapeutic day program service codes are mutually exclusive; a provider cannot bill two *different* day program codes for the member on the same day, though up to 23 units (5 ¾ hours) of the 15 minute code may be billed.
4. A behavioral health medical practitioner, within the scope of his/her practice may bill CPT codes independently for services provided as part of a therapeutic day program.
5. For ALTCS members, therapeutic day program services cannot be billed simultaneously with adult day care services.

Service Codes:

H2019 - Therapeutic Behavioral Health Services, Therapeutic day program, 15 minute increments, daily maximum allowed 5 ¾ hours

H2019 TF - Therapeutic Behavioral Health Services, Therapeutic day program, 15 minute increments, daily maximum allowed 5 ¾ hours

H2019 TF – Therapeutic Behavioral Health Services, Therapeutic day program, home based, 15 minute increments, daily maximum allowed 5 ¾ hours

H2020 - Therapeutic Behavioral Health Services, full day program, 6 hrs or more (per diem)

H2020 - Therapeutic Behavioral Health Services, full day program, home based, 6 hrs or more (per diem)

Service Code Modifier:

TF – Intermediate Level of Care, Use to allow for differential pricing for clients who require a more intensive level of staffing or services.

Place of Service Designation: Specify whether service provided in home (POS 12); mental health center (POS 53), clinic (POS 71), T/RBHA (POS 72) or other (POS 99).

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

PARTIAL CARE Medical Day Program

Provider Type*:

- Outpatient Clinic (provider type 77)

Description of Service:

A regularly scheduled program of active treatment modalities, including medical interventions, in a group setting. Medical day program services may include individual, group and/or family counseling, living skills training, health promotion, supported employment, family support, case management, medication monitoring, methadone administration, medical/nursing assessments and/or other nursing services. Medical day programs must be under the direction of a medical practitioner. Individual staff persons who deliver specific services must meet the provider qualifications for those services.

Service/Reimbursement Limitations:

1. There are no specific limitations on medical day program services for Title XIX/Title XXI members.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously.
3. Medical day program service codes are mutually exclusive; a provider cannot bill two *different* day program codes for the member on the same day, though up to 5 ¾ hours of the 15 minute code may be billed.
4. A behavioral health medical practitioner who supervises the behavioral health day program may not bill this function as a CPT code; employee supervision is built into the program rate.
5. For ALTCS members, medical day program services cannot be billed simultaneously with adult day care services.

Service Codes:

H0036 – Community psychiatric supportive treatment, face-to-face, 15 minutes, (5 ¾ hours maximum)
H0036 TF – Community psychiatric supportive treatment, face to face, 15 minutes (5 ¾ hours maximum)
H0037 – Community psychiatric supportive treatment, per diem
H0036 – Community psychiatric supportive treatment, face to face, home based, 15 minutes, (5 ¾ hours maximum)
H0036 TF – Community psychiatric supportive treatment, face to face, home based, 15 minutes, (5 ¾ hours maximum)
H0037 – Community psychiatric supportive treatment, home based, per diem

Service Code Modifier:

TF – Intermediate Level of Care

Place of Service Designation: Specify whether service provided in home (POS 12), mental health center (POS 53), T/RBHA (POS 72) or other (POS 99).

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Emergency Behavioral Health Care

Provider Types*:

- Hospitals (provider type 02)
- Mental hospitals (provider type 71)
- Outpatient clinics (provider type 77)
- Behavioral Health Medical Practitioners (provider types 08/31, 18, 19)
- Psychologists (provider type 11)
- Sub-acute facilities (provider types B5, B6)
- Level I Crisis Facilities (provider type B7)

Description of Service:

Emergency behavioral health condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect and absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or in the case of pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Ambulance services. The Contractor is responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the member's health.

Emergency behavioral health services are covered inpatient and outpatient services that are

- (a) furnished by a provider qualified to furnish emergency services; and
- (b) needed to evaluate or stabilize an emergency medical condition.

Urgently needed services are covered services that are not emergency services, are provided when a member is temporarily out of their assigned geographic service area or when the Contractor's network is unavailable or inaccessible, when the services are medically necessary and immediately required:

- As a result of unforeseen illness, injury, or condition; and
- It was not reasonable given the circumstances to obtain the services through the member's Contractor.

The member's contractor is responsible for payment and coverage of emergency and urgently needed services

- Regardless of whether the services are obtained within or outside the Contractor's network,
- Regardless of whether there is prior authorization for the services,
- In accordance with the prudent layperson definition of emergency medical condition regardless of final diagnosis.

Post-Stabilization Care Services are services related to an emergency condition, provided after the member is stabilized in a hospital's emergency department, to maintain the stabilized condition or to improve or resolve the member's condition.

Federal Regulations pertaining to ambulance, emergency and urgently needed services and post-stabilization care services are found at 42 CFR422.113 and 42 CFR 438.114.

Delivery System/Fiscal Responsibility:

- The ALTCS EPD Contractor is responsible for an ALTCS EPD member,
- The ALTCS DDD HEALTH PLAN for ALTCS/DDD members not yet RBHA or TRBHA enrolled,
- The AHCCCS Acute Care Health Plan (if acute care member not yet RBHA or TRBHA enrolled),
- The RBHA for an ACUTE CARE HEALTH PLAN member and for an ALTCS/DDD member who is ADHS/RBHA enrolled, or
- AHCCCS for Federal Emergency Services (FES), or for IHS-FFS members not RBHA or TRBHA enrolled,
- ADHS with AHCCCS (as the Third Party Administrator) for members enrolled in a Tribal RBHA.

*The 3-day limitation is not a limit on what the patient may receive, but on the financial liability of the Health Plan.



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Service/Reimbursement Limitations:

1. A provider furnishing emergency services to a member shall notify the contractor (Health Plan [acute or ALTCS/DDD], ALTCS EPD Contractor, or RBHA) within 12 hours from the time a member presents for services.
2. Follow-up visits should not be billed as emergency/crisis visits. (See Case Management Services)
3. Emergency/crisis services provided by behavioral health independent billers may be billed separately.
4. Behavioral health services provided by individuals who are not independent billers must be provided through and billed by a licensed behavioral health agency/facility or hospital.
5. Emergency behavioral health services shall be provided based on the prudent layperson standard and do not require prior authorization.

State Specific Service Codes, CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

BEHAVIOR MANAGEMENT

Behavioral Health Personal Care Services

Provider Types*:

- Habilitation Provider (provider type 39)
- RBHAs and Tribal RBHAs (provider type 72)
- Outpatient Clinics (provider type 77)
- Community Service Agencies (provider type A3)
- Rural Substance Abuse Transitional Agencies (provider type A6)

Description of Service:

Behavioral health personal care services involve the provision of support activities to assist a person in carrying out daily living tasks and other activities essential for living in a community. Services may include assistance with homemaking (cleaning, food preparation, essential errands), personal care (bathing, dressing, oral hygiene), and general supervision and intervention (assistance with self-administration of medications, monitoring of individual's condition and functioning level). Services may involve hands-on assistance such as performing the task for the person or cueing the person to perform the task, and behavior coaching. Services are provided to maintain or increase the self-sufficiency of the person.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on behavioral health personal care services.
2. Behavioral health personal care may not be reimbursed if provided by a member's parent unless the member is 21 years or older.
3. Behavioral health personal care may not be reimbursed if provided by a member's spouse.
4. This service is included in the rate for inpatient, residential, day programs and therapeutic foster care, and may not be billed separately.
5. Member transportation is not included in the rate.
6. Provider transportation is included in the rate and may not be billed separately.

Licensure/Certification:

Personal Care Services are provided by providers who are HCBS-certified to provide this service or by qualified staff of outpatient clinics, community service agencies or RBHAs.

Qualifications for HCBS-certified Habilitation Providers:

Before contracting with a Habilitation provider, T/RBHAs must document in the provider file that the individual:

- Possess current HCBS certification to provide Personal Care services;
- Has in force adequate professional liability and auto insurance;
- Is appropriately screened and references checked before providing services to children.

T/RBHAs must ensure that habilitation providers:

- Are oriented to the specific behavioral health needs of the eligible person by the assigned clinician or designee;
- Know whom to contact in an emergency or other incident involving the member;
- Provide documentation for inclusion in the member's Comprehensive Clinical Record of the dates and time increments of services provided; and that
- Services are periodically reviewed by the assigned clinician and the treatment team as part of the service planning process.

Service Codes:

T1019 – Personal Care Services, 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)

T1020 – Personal Care Services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)

(These two codes are mutually exclusive; they cannot both be billed for the member on the same day.)

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

BEHAVIOR MANAGEMENT Family Support / Home-Care Training

Provider Types*:

- Habilitation Provider (provider type 39)
- RBHA (provider type 72)
- Outpatient Clinic (provider type 77)
- Licensed Independent Social Worker (provider type 85)
- Licensed Marriage/Family Therapist (provider type 86)
- Licensed Professional Counselor (provider type 87)
- Community Service Agency (provider type A3)
- Licensed Independent Substance Abuse Counselor (provider type A4)
- Rural substance abuse transitional agency (provider type A6)

Description of Service:

Family support/home-care training services involve face-to-face interaction with family member(s) directed toward restoration, enhancement or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. Family support/home-care training activities include assisting the family to adjust to the person's disability, develop skills to effectively interact and/or manage the person, understand the causes and treatment of behavioral health issues, understand and effectively utilize the system, or plan long term for the person and the family.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on family support/home-care training services.
2. Family support/home-care training services may be provided while the member is an inpatient of an acute care facility or while in a residential level of care, by providers authorized to provide the service.
3. Member transportation is not included in the rate.
4. Provider transportation is included in the rate and may not be billed separately.

Service Code:

S5110 Home-care Training, Family Support, 15 minute increments

*Not all package types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

BEHAVIOR MANAGEMENT

Behavioral Health Self-help/Peer Support

Provider Types*:

- RBHA (provider type 72)
- Outpatient Clinic (provider type 77)
- Community Service Agency (provider type A3)
- Rural Substance Abuse Transitional Center (provider type A6)

Description of Service:

Peer support services are provided by persons or family members who are or have been consumers of the behavioral health system and who are at least 18 years old. Peer support may involve assistance with more effectively utilizing the service delivery system (assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or assisting the member to understand and cope with the member's disability (support groups), behavior coaching, role modeling and mentoring.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on peer support services.
2. Peer support services may be provided to a member while an inpatient of an acute care facility or while in a residential level of care by providers authorized to provide the service (provider types 72, 77, A3 and A6).
3. Member transportation is not included in the rate.
4. Provider transportation is included in the rate and may not be billed separately.

Service Codes:

H0038 – Self-help/Peer Services, 15 minutes, for up to (but not inclusive of) 7 hours
H2016 – Comprehensive Community Support Services (peer support) – per diem
H0038 and H2016 are mutually exclusive; they cannot both be billed for the member on the same day.
H0038-HQ – Self-help/Peer Services – Group, 15 minutes, for up to (but not inclusive of) 7 hours

Service Code Modifier:

HQ – Group Setting

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

PSYCHOSOCIAL REHABILITATION

Living Skills Training

Provider Types*:

- Outpatient Clinic (provider type 77)
- Community Service Agency (provider type A3)
- Rural Substance Abuse Transitional Agency (provider type A6)
- Licensed: Clinical Social Workers (provider type 85)
- Licensed Marriage & Family Therapists (provider type 86)
- Licensed Professional Counselors (provider type 87)
- Licensed Independent Substance Abuse Counselors (provider type A4)
- HCBS-certified Habilitation Providers (provider type 39)

Description of Service:

Teaching independent living, social and communication skills to persons and/or their families in order to maximize the person's ability to live and participate in the community and to function independently. Areas of skill training may include self-care, household management, social decorum, same- and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of persons or their families with the person(s) present.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on living skills training.
2. If applicable, services provided by behavioral health independent billers (psychiatrists, psychologists, certified psychiatric nurse practitioners, physician assistants, other behavioral health medical practitioners and independent master's level therapists) may be billed independently.
3. Living skills training services are included in the rate for inpatient, residential, day program and therapeutic foster homes and cannot be billed separately.
4. Member transportation is not included in the rate.
5. Provider transportation is included in the rate and may not be billed separately.

Service Codes:

H2014 Living Skills Training – Individual, 15 minute increments
H2014-HQ Living Skills Training – Group, per person, 15 minute increments
H2017 Living Skills Training – Extended, 3 or more hours, 15 minute increments

Service Code Modifier:

HQ – Group Setting

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

PSYCHOSOCIAL REHABILITATION

Supported Employment Services

Provider Types*:

- Outpatient Clinic (provider type 77)
- Community Service Agency (provider type A3)
- Rural Substance Abuse Transitional Agency (provider type A6)
- Licensed: Clinical Social Workers (provider type 85)
- Licensed Marriage & Family Therapists (provider type 86)
- Licensed Professional Counselors (provider type 87)
- Licensed Independent Substance Abuse Counselors (provider type A4)

Description of Service:

Supported employment services are designed to assist a person or group to choose, acquire and maintain a job or other community activity such as volunteer work. Supported employment services include:

- Pre-job training/education and development: activities to prepare a person to engage in meaningful work-related activities which may include career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, work activities, professional decorum and dress, time management, and assistance in finding employment.
- Job coaching and employment support: activities that enable a person to complete job training or maintain employment such as monitoring and supervision, assistance in performing job tasks, work-adjustment training, and supportive counseling.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on supported employment services.
2. If applicable, services provided by behavioral health independent billers (psychiatrists, psychologists, certified psychiatric nurse practitioners, physician assistants, other behavioral health medical practitioners and independent master's level therapists) may be billed independently.
3. Supported employment services are included in the rate for inpatient, residential, day program and therapeutic foster homes and cannot be billed separately.
4. Member transportation is not included in the rate.
5. Provider transportation is included in the rate and may not be billed separately.

Service Codes:

H2027 - Pre-job training/education and development, 15 minute increments

H2025 – Job coaching and employment support, 15 minute increments

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

PSYCHOSOCIAL REHABILITATION

Health Promotion

Provider Types*:

- Outpatient Clinic (provider type 77)
- Community Service Agency (provider type A3)
- Rural Substance Abuse Transitional Agency (provider type A6)

This service must be provided by behavioral health professionals or behavioral health technician

Description of Service:

Education and training provided to a group of persons and/or their families related to the enrolled person's treatment plan on health-related topics such as the nature of illness, relapse and symptom management, medication management, stress management, safe sex practices, HIV education, and healthy lifestyles.

Service/Reimbursement Limitations:

1. For Title XIX/Title XXI members there are no specific limitations on health promotion services.
2. There are no limits on size of group.
3. If applicable, services provided by behavioral health independent billers (psychologists, behavioral health medical practitioners and independent master's level therapists) may be billed separately using appropriate CPT codes.
4. Health Promotion services are included in the rate for inpatient, residential, day program and therapeutic foster homes and cannot be billed separately.
5. Member transportation is not included in the rate.
6. Provider transportation is included in the rate and cannot be billed separately.

Service Codes:

H0025 – Health promotion, 30 minute increments, per person
H0034 – Health promotion, medication training per 15 minutes

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Behavioral Health Case Management

Provider Types*:

- RBHA or TRBHA (provider type 72)
- Outpatient Clinic (provider type 77)
- Licensed Clinical Social Worker (provider type 85)
- Licensed Marriage and Family Therapist (provider type 86)
- Licensed Professional Counselor (provider type 87)
- Licensed Independent Substance Abuse Counselor (provider type A4)

Description of Service:

Behavioral health case management services are supportive services provided to enhance treatment compliance and effectiveness. Case management activities include assistance in accessing, maintaining, monitoring and modifying covered services; assistance in finding resources, communication and coordination of care, outreach and follow-up of crisis contacts or missed appointments.

Service/Reimbursement Limitations:

1. There are no specific behavioral health case management limitations for Title XIX/Title XXI acute care or ALTCS-DDD members.
2. Case Management services for ALTCS EPD members are provided by ALTCS case managers. ALTCS program contractors may authorize the provision of limited behavioral health case management services by outpatient clinics with whom they contract.
3. Case Management Services may be provided by behavioral health professionals, behavioral health technicians or behavioral health paraprofessionals as defined in 9 A.A.C. 20. If case management services are not provided by the primary behavioral health professional or assigned clinician, these services must be provided under their direction or supervision.
4. Case management codes may not be billed for any time associated with a therapeutic interaction.
5. Case management services provided to a Title XIX/Title XXI member while an inpatient of a hospital, sub-acute or residential facility may be billed by providers specifically registered to provide those services.
6. Other behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals providing case management services must be affiliated with an outpatient clinic or RBHA and use the applicable 'T' code.
7. More than one provider agency may bill for this service during the same time period when more than one provider is providing case management services. More than one individual within an agency may bill for the service (e.g., internal staffings), but billing is limited to individuals who are *directly* involved with service provision to the person.
8. Transportation of members is not included in the rate.

Service Codes:

T1016 GT or HO – Office Case Management by behavioral health professional, 15 minutes
T1016 HO – Out of Office Case Management by behavioral health professional, 15 minutes
T1016 GT or HN – Office Case Management by technician or paraprofessional, 15 minutes
T1016 HN – Out of Office Case management by technician or paraprofessional, 15 minutes

Service Code Modifiers:

GT – Telecommunication, HN – Bachelors Degree Level, HO – Masters Degree Level

Place of Service Designation: Specify whether service provided in office (POS 11), in home (POS 12), outpatient hospital (POS 22), Federally Qualified Health Center (POS 50), community mental health center (POS 53), public health clinic (POS 71), T/RBHA (POS 72) or other (POS 99).

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

* For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at: http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Nursing Services

Provider Types*:

- Outpatient Clinics (provider type 77)
- Rural Substance Abuse Transitional Agency (provider type A6)

Services must be provided by Arizona licensed registered nurses and licensed practical nurses within their scope of practice.

Description of Service:

Nursing services, as allowed by the provider's scope of practice, may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

Service/Reimbursement Limitations:

- Travel time by the provider is included in the rate for nursing services.
- Nursing services provided in an inpatient or residential setting or medical day program setting are included in the rate and cannot be billed separately.

Service Codes:

- T1002 - RN Services, 15 minutes (daily limits vary by program – check with contractor for allowed daily maximum)
- T1003 - LPN/LVN Services, 15 minutes (daily limits vary by program – check with contractor for allowed daily maximum)

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Psychotropic Medication

Provider Types*:

- Pharmacy (provider type 03)
- Physician (provider type 08/31)
- Certified Psychiatric Nurse Practitioner (provider type 19)
- Physician's Assistant (provider type 18)
- Outpatient Clinic (provider type 77)

Description of Service:

Psychotropic and related medications, which have been prescribed by a licensed physician, certified nurse practitioner, or physician assistant that address the therapeutic goals outlined in the member's service plan.

Service/Reimbursement Limitations:

1. There are no specific limitations for psychotropic medication for Title XIX or Title XXI members.
2. Reimbursement for psychotropic medications is included in the per diem rate for inpatient hospital and psychiatric hospital services and cannot be billed separately.
3. Psychotropic medications provided in an RTC or sub-acute facility are not included in the per diem rate unless otherwise specified in contract and may be billed by a provider registered with AHCCCS as a provider of this specific service.
4. Psychotropic medications are reimbursed per dispensed medication with a preset dispensing fee or per injection.

Service Codes:

- NDC Codes
- 90782, J1631, J2680
- All oral medications

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Laboratory and Radiology Services for Diagnosis and Medication Regulation

Provider Types*:

- Medical laboratory (provider type 04)
- Physician (provider type 08/31)
- Physician assistant (provider type 18)
- Certified psychiatric nurse practitioner (provider type 19)
- Outpatient hospital (provider type 02)

With the exception of in-office specimen collection, only providers with an approved CLIA certification can bill or encounter for a lab service.

Description of Service:

Laboratory and radiology services include blood and urine tests, CT scans, MRI, EEG which are used to regulate and monitor psychotropic medications and to diagnose mental illnesses.

Service/Reimbursement Limitations:

1. Laboratory and radiology services are not limited for Title XIX or Title XXI members.
2. Laboratory and radiology tests are included in the per diem rate for all inpatient hospital settings and cannot be billed separately.
3. Laboratory and radiology services provided for a member residing in an RTC or sub-acute facility may be billed by a provider registered with AHCCCS as a provider of this specific service.
4. Laboratory and radiology services are reimbursable per test or procedure.

Provider Qualifications:

Laboratory and radiology services shall be provided by medical laboratories and outpatient hospitals that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4. Medical laboratories must be registered in accordance with the federal Clinical Laboratory Improvement Amendments. Reference A.R.S. Title 36, Chapter 4.1 et seq., R9-14-101; 42 U.S.C. 263a; 42 CFR 493.

Service Codes:

CPT and HCPCS codes appropriate to provider type, scope of practice and AHCCCS policy.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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Transportation

Provider Types*:

- Emergency Transportation Providers (provider type 06)
- Non-emergency (non-ambulance) transportation (provider type 28)
- Hospitals (provider type 02)
- Psychiatric hospital (provider type 71)
- RBHA and Tribal RBHA (provider type 72)
- Outpatient clinic (provider type 77)

Description of Service:

Transportation services include emergency and non-emergency medically necessary transportation to and from settings providing Title XIX and Title XXI covered behavioral health services. Coverage of medically necessary transportation is provided when members are unable to provide their own transportation for medically necessary services.

Service/Reimbursement Limitations:

1. For services in which travel time and mileage (under 25 miles) by the provider have been included in the rate (i.e. individual counseling, out of office), travel time by the provider may not be billed separately. The provider may only bill the time spent in face-to-face contact.
2. For services in which mileage incurred by the provider has been included in the rate (i.e., individual counseling, out of office), the mileage may not be billed separately except when mileage incurred by the provider exceeds 25 miles. In that instance, providers may bill A0160 for miles in excess of 25. Multiple segments of a trip each include the assumption of 25 miles included.

For thorough discussion of transportation billing requirements/limitations refer to the AHCCCS Provider Manual, available on-line at <http://infonet/Publications/ProvMan/chapt18.pdf> and the ADHS/DBHS Covered Behavioral Health Services Guide at http://www.hs.state.az.us/bhs/bhs_gde.pdf

Provider Qualifications:

A.R.S. Title 41, Chapter 12; A.R.S. Title 36, Chapter 21.1; R9-22-211

Service Codes:

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Opioid Agonist Treatment

Provider Types*:

- Physician (provider type 08,31)
- Physician Assistant (provider type 18)
- Nurse Practitioner (provider type 19)

Description of Service:

Administration of prescribed opioid agonist drugs to a person in the office setting or for a person to take at home in order to reduce physical dependence on heroin and other opiate narcotics.

Service Limitations:

Methadone/LAAM or other opioid agonists may only be prescribed by a medical practitioner within the scope of his/her practice who is registered with AHCCCS as an authorized service provider.

Service/Reimbursement Limitations:

1. Opioid agonist administration codes (office and take home) may be billed only one dose per day.
2. The take home (H0020 HG) code is for a single dose of medication, but it can be provided for more than one day.

Service Codes:

H0020 HG – Alcohol and/or Drug Services; Methadone Administration and/or Service (take home)
H2010 HG – Comprehensive Medication Services, 15 minutes (office)

Service Code Modifier:

HG – Opioid Addiction Treatment Program, modifier must be used.

*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

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Respite Care

Provider Types*:

- Outpatient Clinic (provider type 77)
- RBHA (provider type 72)
- Level 2 Behavioral Health Agency (provider type 74)
- Level 3 Behavioral Health Agency (provider type A2)
- Therapeutic Foster Care Home (provider type A5)
- Community Service Agency (provider type A3)
- HCBS Certified Habilitation Providers (provider type 39)

Description of Service:

Short term or intermittent care and supervision of a member to provide an interval of rest and/or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during the respite period.

Service/Reimbursement Limitations:

1. Respite Care Services are available to Title XIX and Title XXI members.
2. Services provided by Respite care providers employed by a licensed behavioral health clinic, RBHA or community service agency must be billed through these provider agencies.
3. Respite services are reimbursable as follows:
 - Short term respite is in 15 minute units up to 12 hours (for utilization greater than 13 hours, use continuous respite code).
 - Continuous respite is a 24 hour day.

Qualifications for Respite Providers:

Before contracting with a Respite provider, T/RBHAs must document in the provider file that the individual:

- Possess current HCBS certification to provide respite care services;
- Has in force adequate professional liability and auto insurance;
- Is appropriately screened and references checked before providing services to children.

T/RBHAs must ensure that respite providers:

- Are oriented to the specific behavioral health needs of the eligible person by the assigned clinician or designee;
- Know whom to contact in an emergency or other incident involving the member;
- Provide documentation for inclusion in the member's Comprehensive Clinical Record of the dates and time increments of services provided; and that
- Services are periodically reviewed by the assigned clinician and the treatment team as part of the service planning process.

Service Codes:

S5150 - Short term in-home respite care, 15 minute increments up to 12 hours (for utilization greater than 13 hours use continuous respite code)

S5151 - Continuous in-home Respite Care, 24 hour day, per diem

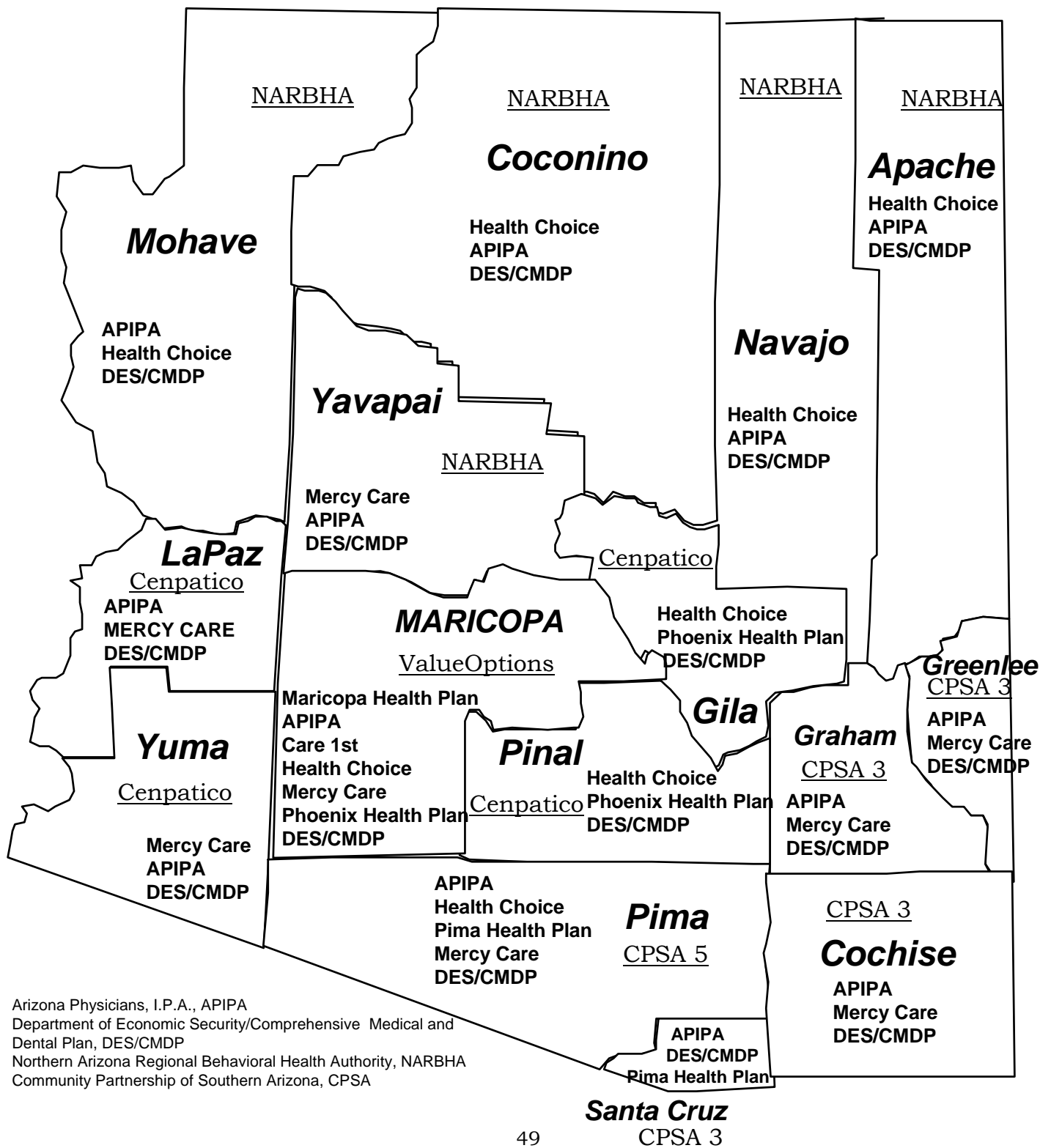
*Not all provider types can bill every code. For the list of allowable procedure codes by provider type, contractors and providers with access to the AHCCCS PMMIS screens can refer to screen RF618. Information also available on the ADHS/DBHS Provider Types and Allowable Procedure Codes Matrix, on-line at:

http://www.hs.state.az.us/bhs/app_b2.pdf



AHCCCS Behavioral Health Services Guide Exhibit A

Acute Care Health Plans and RBHAs by County





**AHCCCS Behavioral Health Service Guide
Exhibit B**

**ALTCS Program Contractor Map
for Elderly/Physically Disabled (EPD) Program**





AHCCCS Behavioral Health Service Guide Exhibit C

ALTCS DES/DD Map with Contracted Health Plans and RBHAs by County

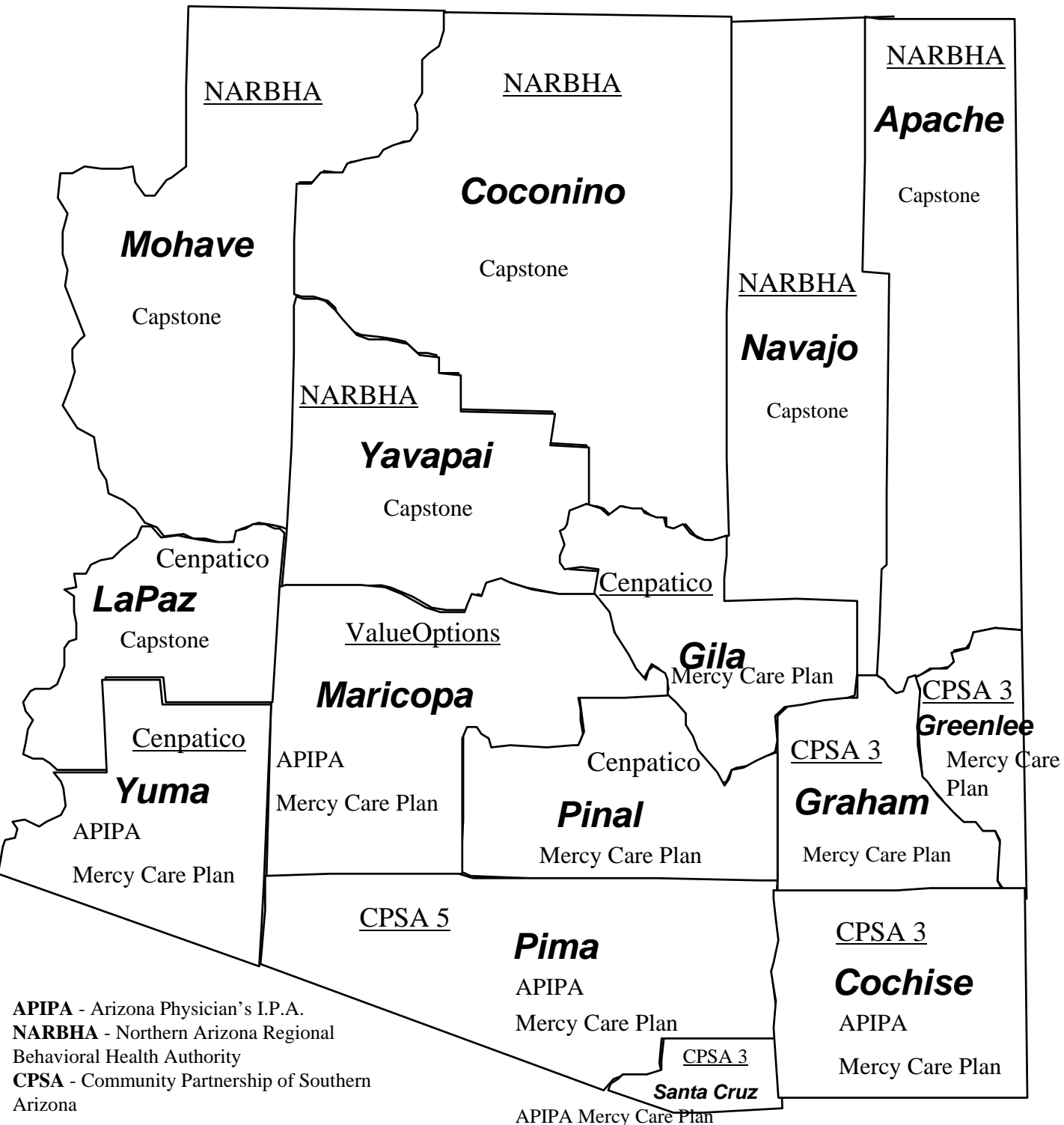


Exhibit D**AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE****AHCCCS Acute Care Health Plan Phone Numbers**

NAME	COUNTIES OF OPERATION	MEMBER SERVICES NUMBER
Arizona Physicians IPA (APIPA)	Coconino, Yavapai, Cochise, Santa Cruz, Graham, Greenlee, LaPaz, Yuma, Mohave, Maricopa, Navajo, Apache, Pima,	800-348-4058
Care 1st	Maricopa	602-778-1800
Comprehensive Medical and Dental Plan (CMDP)	Statewide	602-351-2245 800-201-1795
Health Choice Arizona	Maricopa, Pima, Apache, Coconino, Mohave, Navajo, Gila, Pinal	480-968-6866 800-322-8670
Maricopa Health Plan	Maricopa	602-344-8700 800-582-8686
Mercy Care Plan	Cochise, Graham, Greenlee, Yavapai, Maricopa, Pima, Yuma, LaPaz	602-263-3000 800-624-3879
Phoenix Health Plan/Community Connection	Maricopa, Gila, Pinal	602-824-3700 800-747-7997
Pima Health Plan	Pima	520-512-5500 800-423-3801

Exhibit E**AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE****ALTCS PROGRAM CONTRACTOR PHONE NUMBERS**

NAME	COUNTIES OF OPERATION	MEMBER SERVICES NUMBER
Cochise Health System	Cochise, Graham, Greenlee	800-285-7485
DES/DDD	Statewide	602-238-9028 1-800-624-4964
Maricopa Long Term Care Plan	Maricopa	602-344-8700 1-800-582-8686
Mercy Care Plan	Maricopa	602-263-3000 800-624-3879
Pima Health System	Pima, Santa Cruz	520-512-5500 800-423-3801
Pinal County LTC	Pinal, Gila	520-866-6775 822-831-4213
Evercare Select (Formerly Lifemark)	Apache, Coconino, La Paz, Mohave, Navajo, Maricopa, Yuma	602-331-5100 800-293-0039
Yavapai County LTC	Yavapai	928-771-3560 800-850-1020
AHCCCS FFS (ALTCS)	Statewide	Central Office (Clinical Quality Management) (602) 417-4410

Exhibit F



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE DES/DD Contracted Health Plan Phone Numbers

NAME	COUNTIES OF OPERATION	HEALTH PLAN DD LIAISONS
Arizona Physician's I.P.A. (APIPA)	Cochise, Maricopa, Pima, Santa Cruz, Yuma	602-664-5394
Mercy Care Plan	Cochise, Gila, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz, Yuma	602-263-3995

Exhibit G



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Tribal Contractor Phone Numbers

Contractor	Address	Phone Number
Gila River Indian Community Public Health Nursing	P.O. Box 38 Sacaton, AZ 85247	(602) 528-1200
Native American Community Health Center	3008 N. 3 rd St., Suite 310 Phoenix, AZ 85012	(602) 279-5262
Navajo Nation Social Services Administration	P.O. Box 4590 Window Rock, AZ 86515	(928) 871-6174
Navajo Nation Social Services Tuba City	P.O. Box 280 Tuba City, AZ 86045	(928) 283-3250
Navajo Nation Long Term Care Chinle	P.O. Box 1000 Chinle, AZ 86503	(928) 674-2236
Navajo Nation/Fort Defiance Long Term Care	P.O. Box 950 Fort Defiance, AZ 86504	(928) 729-4064
Pascua Yaqui Tribe	7474 S. Camino de Oeste Tucson, AZ 85746	(520) 883-5020 (520) 879-6060
San Carlos Apache Tribe Social Services	P.O. Box 0 San Carlos, AZ 85550	(928) 475-2138
Tohono O'Odham Nation Senior Services	P.O. Box 810 Sells, AZ 85634	(520) 383-6075
White Mountain Apache Tribe Client Business Office	P.O. Box 1210 Whiteriver, AZ 85941	(928) 338-1808

Exhibit H

AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE
Regional Behavioral Health Authorities
(RBHAs)

NAME	COUNTIES OF OPERATION	MEMBER SERVICES NUMBER
ValueOptions	Maricopa	800-564-5465 After 5 p.m., callers can choose prompt for crisis line (staffed 24 hours) or call 602-222-9444 directly
Community Partnership of Southern Arizona (CPSA)	Pima, Santa Cruz, Cochise, Graham, Greenlee	800-771-9889 After 11 p.m. calls roll over to SAMHC (staffed 24 hours)
Northern Arizona Regional Behavioral Health Authority (NARBHA)	Coconino, Mohave, Navajo, Apache, Yavapai	928-774-7128 800-640-2123 After 5 p.m., calls roll over to an answering service. Crisis calls are directed to crisis providers.
Cenpatico	Pinal, Gila, Yuma, La Paz	Member Services 866-495-6738 Pinal County Gila County Yuma County La Paz County

Tribal Regional Behavioral Health Authorities and Contractors

NAME	MEMBER SERVICES NUMBER	WEB SITE ADDRESS
Pascua Yaqui Regional Tribal Behavioral Health Authority	520-879-6060	http://www.pascuayaqui-nsn.gov/community/programs/health/behavioral/index.shtml
Gila River Tribal Regional Behavioral Health Authority	602-528-1206	http://www.gilariverrbha.org/index/htm
Navajo Nation Behavioral Health Contractor	928-871-6877	http://www.navajo.org/

Exhibit I



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

Indian Health Service

Phoenix Area Indian Health Service (IHS) Two Renaissance Square , Room 504 40 North Central Avenue Phoenix, Arizona 85004-4424	(602) 364-5140 Fax: (602) 364-5269
Phoenix Indian Medical Center 4212 North 16 th Street Phoenix, Arizona 85016	(602) 263-1200 Fax: (602) 263-1699
Tucson Area Indian Health Service (IHS) 7900 South J. Stock Road Tucson, Arizona 85746-7012	(520) 295-2406 Fax: (520) 295-2610
Navajo Area Indian Health Service (IHS) P.O. Box 9020 Window Rock, Arizona 86515-9020	(928) 871-5811 Fax: (928) 871-5872

Exhibit J



AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE Federal Utilization and Seclusion/Restraint Requirements

Federal Requirement	Psychiatric Hospital	Acute General Hospital or a Distinct Unit of an Acute General Hospital	Inpatient Psychiatric Facilities (Sub-acute and RTC's)
Certification of Need	42 CFR 456.160	42 CFR 456.60	42 CFR 441.152 to 156
Recertification of Need	42 CFR 456.160	42 CFR 456.60	42 CFR 441.155
Plan of Care	42 CFR 441.102 or 456.180 to 181	42 CFR 456.80	42 CFR 441.155 to 156 and 456.180
UR Plan/Committee	42 CFR 456.200 to 213 and 482.30	42 CFR 456.100 to 113 and 482.30	The certification specified in 441.152 and 153 satisfies the utilization control requirement for physician certification in 456.60, and 456.160.
UR Admission Review	No requirement	42 CFR 456.121 to 127	
Evaluation and Admission Review	42 CFR 456.170 - 171	42 CFR 456.128 to 132	
Initial Continued Stay Review	42 CFR 456.233	42 CFR 456.133 to 137	
Subsequent Continued Stay Review	42 CFR 456.231 to 238	42 CFR 456.141 to 145	
Medical Care Evaluation	42 CFR 456.241 to 245	42 CFR 456.141 to 145	Required by state contract
Active Treatment	See Plan of Care requirements	See Plan of Care requirements	42 CFR 441.154
Quarterly Showing Report	42 CFR 456, Subpart J	42 CFR 456, Subpart J	42 CFR 456, Subpart J
Seclusion and Restraint	42 CFR 482.13	42 CFR 482.13	42 CFR 483, Subpart G
Accreditation Requirement	JCAHO Inpatient Standards	JCAHO Inpatient Standards	JCAHO, COA or CARF



INSTITUTIONS FOR MENTAL DISEASES (IMD)

An Institution for Mental Disease (IMD) is defined at 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)]. Effective July 5, 2000, HCFA (CMS) granted Arizona expenditure authority to provide limited services to Title XIX persons age 21 through 64 in IMDs. Based on current ADHS/OBHL licensing language, facilities which meet the definition of an IMD are licensed Level I facilities with more than 16 total treatment beds. General acute care hospitals with psychiatric units *are not* considered IMDs.

Settings/Provider Types:

- Level I Psychiatric Hospital (provider type 71)
- Level I Residential Treatment Center with more than 16 beds (provider types B1 and B3)
- Level I Sub-acute facility with more than 16 beds (provider type B6)
- Medicare certified nursing facility with more than 16 beds and more than 50% of patients are primarily treated for mental disorders (provider type 22)

Service Limitations:

- A Title XIX member who is 21 years through 64 years old may receive services in an IMD for up to 30 days per admission and 60 days per contract year (July 1 – June 30). The member remains eligible for other Title XIX covered services during the 30/60 days. However, a member whose stay exceeds 30 days per admission/60 days per contract year may lose Title XIX eligibility.
- An admission which spans contract years is counted as one admission; only 30 days of the admission are reimbursable with Title XIX/Title XXI funds.
- There are no length of stay limits (30 days per admission/60 days per contract year) for a Title XIX member under age 21 (EPSDT members) or age 65 and older in IMDs, provider types B1, B3 and B6.
- For Title XXI members, there are no service limitations. However, an individual may not apply for Title XXI eligibility nor be re-determined for such eligibility while residing in an IMD. A Title XXI KidsCare member whose annual eligibility re-determination date occurs while the individual is residing in an IMD will be disenrolled from KidsCare and evaluated for Medicaid Title XIX eligibility.
- AHCCCS Contractors must ensure that IMD agencies provide written notification to a Title XIX member or the member's parents or legal guardian at admission that:
 - AHCCCS eligibility for members who are age 21 through 64 may end if they remain in an IMD longer than 30 days per admission or 60 days per contract year (July 1 – June 30). After 30 days the setting is considered to be an ineligible setting and the member is not entitled to receive any Medicaid service, either inside or outside of the facility, while remaining as a resident.

Reimbursement Limitations/Provider Requirements:

- The Arizona State Hospital must report all admissions of Title XIX or Title XXI members to AHCCCS Member Services (fax: 602-253-4807 or telephone: 602-417-4412).
- IMDs, other than the Arizona State Hospital, are required to notify AHCCCS Member Services (fax: 602-253-4807 or telephone: 602-417-4412) when a Title XIX member age 21 through 64 years old has been a resident/inpatient for 30 consecutive days and provide the following information:
 - *Provider* Identification Number and telephone number
 - *Recipient's* name, date of birth, AHCCCS Identification Number *and* Social Security Number
 - Date of admission



INSTITUTIONS FOR MENTAL DISEASES (IMD)

AHCCCS eligibility for a member whose admission has been reported as exceeding 30 days will be 'suspended' for the remainder of the admission. IMD Providers are required to notify AHCCCS Division of Members Services (DMS) when the member is discharged so that eligibility can be restored. This limited tracking of member admissions/discharges will not function to collect cumulative utilization. Contractors and providers should be aware that due to claims and encounter lags, they cannot rely on timely tracking of utilization at the state agency level (AHCCCS and ADHS/DBHS) and are therefore encouraged to solicit utilization information from client history, medical records and other measures as appropriate. Facilities other than the Arizona State Hospital should *not* report admissions of members who are less than 21 years old or age 65 and older to AHCCCS but must report such admissions to RBHAs or ALTCS Contractors. ALTCS Contractors and ADHS or designee must monitor members age 21 through 64 cumulative utilization and report to DMS when a member reaches 60 cumulative days.

KidsCare:

Admission/discharge notification is *not* reported to AHCCCS Administration for members age 20 and younger. AHCCCS Title XXI members can be admitted to an IMD if they are *already* eligible for Title XXI. However, federal regulations prohibit application or redetermination for Title XXI while a resident of an IMD. Provider types which identify IMD status of Residential Treatment Centers have therefore been established: provider types B1 and B3 **are** IMDs; provider types 78 and B2 **are not** IMDs for KidsCare redetermination purposes only. KidsCare members in IMDs will be evaluated for Title XIX eligibility at the end of their KidsCare eligibility period.



FACT SHEET INDEPENDENT MASTER'S LEVEL THERAPISTS

Effective July 1, 2004, an individual licensed per A.R.S. Title 32, Chapter 33, by the Arizona Board of Behavioral Health Examiners (ABBHE) as a Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC), or Licensed Independent Substance Abuse Counselor (LISAC) is allowed to register with AHCCCS as one of the following provider types:

LCSW	Provider Type 85
LMFT	Provider Type 86
LPC	Provider Type 87
LISAC	Provider Type A4

Although ABBHE licenses other individuals with master's and/or bachelor's degrees, only the above- identified licensure categories are permitted to register as independent billers with AHCCCS.

Providers are required to:

- Complete an application
- Sign a provider agreement and other applicable forms
- Submit documentation of current ABBHE licensure
- Submit Form W-9: Request for Taxpayer Identification Number and Certification

When a provider's application is approved, an AHCCCS ID number is assigned and the provider is notified by letter.

The scope of practice for LISACs is limited by ABBHE to the assessment and treatment of individuals and families with substance abuse issues. LCSWs, LPCs and LMFTs can treat both mental illness and substance abuse. For FFS claims to AHCCCSA, the CPT codes (90000) will pay at 75% of the posted (physician) rate. Capitated Contractors may contract with providers at, above or below the AHCCCS FFS posted rate.

Information and registration materials may be obtained by calling the AHCCCS Provider Registration Unit at (602) 417-7670, (Option 5) or 1-800-794-6862 or are available on line at: <http://www.ahcccs.state.az.us/PlansProviders/ProviderRegistration.asp> .

ALTCS Contractors and RBHAs must credential and privilege these therapists within their delivery system. However, privileging/credentialing or offering a contract is **not** required prior to AHCCCS registration.



FACT SHEET

Responsibility For Behavioral Health Emergency and Post-Stabilization Care Services

Behavioral health recipient or RBHA or TRBHA Enrolled:

Title XIX or Title XXI members who are considered behavioral health recipients are individuals who are Title XIX or Title XXI *eligible at the time the service was provided and enrolled with a RBHA or TRBHA as a Title XIX or Title XXI member.* (For purposes of this document, ‘behavioral health recipient’ or RBHA/TRBHA enrolled does not include individuals receiving RBHA services during prior period eligibility segments).

Emergency Behavioral Health Service:

Covered inpatient and outpatient services provided to treat an emergency behavioral health condition. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency behavioral health condition.

Emergency Behavioral Health Condition:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) a psychiatric emergency involving a significant risk of serious harm to oneself or others; b) a substance abuse emergency exists if there is significant risk of serious harm to a behavioral health recipient or others, or there is likelihood of return to substance abuse without immediate treatment.

Emergency Medical Condition:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Post-Stabilization Care Services:

Services related to an emergency condition, provided after the member is stabilized in a hospital’s emergency department (regulations do not pertain to psychiatric urgent care centers), to maintain the stabilized condition or to improve or resolve the member’s condition.

For Title XIX and Title XXI behavioral health recipients, post- stabilization care services are the fiscal responsibility of:

- The **ALTCS EPD** Contractor for an ALTCS EPD member;
- The **ALTCS DDD HEALTH PLAN** for ALTCS/DDD members not yet RBHA or TRBHA enrolled;
- The **AHCCCS Acute Care Health Plan** (if acute care member not yet RBHA or TRBHA enrolled);
- The **RBHA** for an ACUTE CARE HEALTH PLAN member and for an ALTCS/DDD member who is ADHS/RBHA enrolled;
- **AHCCCS** for IHS-FFS members not RBHA or TRBHA enrolled;
- **ADHS with AHCCCS (as the Third Party Administrator)** for members enrolled in a Tribal RBHA.

Upon the determination by the attending emergency department physician that a member is sufficiently stabilized for discharge, transfer or admission, the emergency department should contact the member’s Contractor for determination of where post stabilization services are to be provided. If the Contractor does not respond within **one hour** of being contacted, the emergency department may discharge, transfer



FACT SHEET

Responsibility For Behavioral Health Emergency and Post-Stabilization Care Services

or admit the member to a facility and the Contractor is responsible for coverage and payment whether the facility is within or outside the Contractor's network. [42 CFR 438.114(b) and 42 CFR 422.113(c)]

Providers should refer to the following outline to determine the responsible Contractor when making contact for post-stabilization care authorizations. Providers need not contact AHCCCS Administration for authorization for post-stabilization care services provided to FFS members, but must always notify/make a referral to the RBHA as soon as possible upon admission for behavioral health services, preferably within 24 hours but in no case later than 10 calendar days post admission. See Exhibits D – H for Contractor contact information.

1. For members enrolled in ALTCS DES/DDD, DES/CMDP, or an ACUTE CARE HEALTH PLAN (other than IHS), check to see if the member is enrolled with a RBHA or Tribal RBHA.

A. If the member is enrolled with a RBHA:

- Emergency Department: All services provided in the emergency department are the responsibility of the member's health plan with the exception of a behavioral health consult provided by a behavioral health medical practitioner, licensed psychologist, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist which is the RBHA's responsibility. Prior authorization for these consults is not required if associated with an emergency.
- Post-stabilization care services-Inpatient: Coverage and payment for an admission for a behavioral health disorder or detoxification is the RBHA's responsibility. (However, for admissions where the primary condition is medical with the need for detoxification being secondary, the acute care health plan is responsible for coverage and payment.)

B. If the member is enrolled with a Tribal RBHA (for services provided in non-IHS, non- 638 tribal facility):

- Emergency Department: All claims for services provided in the emergency department are the responsibility of the health plan with the exception of a behavioral health consult provided by a behavioral health medical practitioner, licensed psychologist, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist which are the responsibility of ADHS, with AHCCCS paying claims as Third Party Administrator (TPA) for ADHS.
- Post-stabilization care services-Inpatient: Coverage and payment for an admission for a behavioral health disorder or detoxification is the responsibility of ADHS, with AHCCCS paying claims as Third Party Administrator (TPA) for ADHS. (However, for admissions where the primary condition is medical with the need for detoxification being secondary, the acute care health plan is responsible).
- The contact for post-stabilization care services can be made to the ADHS/DBHS Division of Behavioral Health Services/Bureau of Quality Management and Evaluation during regular business hours, or within 24 hours of an admission made



FACT SHEET
Responsibility For Behavioral Health
Emergency and Post-Stabilization Care Services

after 5:p.m. Monday through Friday, on weekends or State holidays. (Fax (602) 364-4749, telephone (602)364-4645.

C. If the managed care DDD, CMPD or health plan member is not enrolled with a RBHA or Tribal RBHA:

- Emergency Department: All claims for emergency medical services are the responsibility of the health plan, including triage, physician assessment, diagnostic tests, professional charges for a behavioral health consult provided by a behavioral health medical practitioner, licensed psychologist, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist. Prior authorization for these consults is not required if associated with an emergency.
- Post-stabilization care services-Inpatient: Coverage and payment for an admission for a behavioral health disorder or detoxification is the responsibility of the health plan. *A referral to the RBHA should be made as soon as possible, but no later than 24 hours after admission.*

The member's health plan may be responsible for up to 3 days of inpatient care services, for a maximum of 12 days per health plan contract year (October 1-September 30). The *member's benefit* is not limited to 3 days, only the health plan's responsibility.

A referral to the RBHA or Tribal RBHA should be made as soon as possible after admission. The RBHA or a Tribal RBHA should respond to a referral within 24 hours, evaluate the patient, and if the patient is assessed as needing behavioral health services, immediately enroll the patient in the RBHA or Tribal RBHA, as applicable, and assume responsibility for provision of any continued behavioral health services.

2. For FFS members enrolled with INDIAN HEALTH SERVICES (IHS) for services provided at non-IHS or non-638 tribal facilities, check to see if the member is enrolled with a RBHA or Tribal RBHA.

A. If the FFS member is enrolled with a RBHA:

- Emergency Department: All services provided in the emergency department are the responsibility of AHCCCS (not as TPA) with the exception of a consult provided by a behavioral health medical practitioner, licensed psychologist, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist which is the RBHAs responsibility. Prior authorization for these consults is not required if associated with an emergency.
- Post-stabilization care services-Inpatient: Coverage and payment for an admission for a behavioral health disorder or detoxification is the responsibility of the RBHA. (However, for admissions where the primary condition is medical with the need for detoxification being secondary, the health plan is responsible). *A referral to the RBHA advising their member has been admitted should be made as soon as possible, but no later than 24 hours after admission.*

B. If the member is enrolled with a Tribal RBHA:

- Emergency Department: All services provided in the emergency department are the responsibility of ADHS (with AHCCCS paying claims as the TPA) with the exception of a consult provided by a behavioral health medical practitioner, licensed psychologist,



FACT SHEET

Responsibility For Behavioral Health Emergency and Post-Stabilization Care Services

licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist which is the RBHAs responsibility. Prior authorization for these consults is not required if associated with an emergency.

- Post-stabilization care services-Inpatient: Coverage and payment for an admission for a behavioral health disorder or detoxification is the responsibility of ADHS*, with AHCCCS paying claims as the TPA for ADHS. *A referral to the Tribal RBHA advising their member has been admitted should be made as soon as possible, but no later than 24 hours after admission.* Exception: Admissions for detoxification when the primary condition is medical are the responsibility of AHCCCS (not as TPA). See post-stabilization care services, above.

*The contact for post-stabilization care services can be made to the ADHS/DBHS Division of Behavioral Health Services/Bureau of Quality Management and Evaluation during regular business hours. Notification of an admission made after 5:p.m. Monday through Friday, on weekends or State holidays must be made within 24 hours. **Telephone** (602)364-4645, **Fax** (602)364-4749.

C. If the IHS member is not enrolled with a RBHA or Tribal RBHA:

- Emergency Department: The AHCCCS Administration (not as the TPA for ADHS) is responsible for claims payment for emergency services, including professional charges for a psychiatrist or licensed psychologist consult.
- Post-stabilization care services-Inpatient: Coverage and payment for an admission for a behavioral health disorder or detoxification is the responsibility of AHCCCS** (not as the TPA for ADHS).

**Inpatient providers need not contact AHCCCS Administration for authorization for post-stabilization care services provided to FFS members, but must notify the RBHA as soon as possible upon admission, preferably within 24 hours but in no case later than 48 hours. The RBHA or Tribal RBHA should respond to the referral within 24 hours and evaluate/enroll patient in the RBHA/TRBHA and assume responsibility for provision of any continued behavioral health services.

3. ALTCS Elderly and Physically Disabled (EPD) members do not enroll with RBHAs or TRBHAs. For DES/DDD ALTCS members see # 1 above.

A. For members enrolled with an ALTCS EPD Contractor:

Emergency Department and post-stabilization care services are the responsibility of the program contractor. For ALTCS Contractors there is no 72-hour limitation of responsibility. All medically necessary services are covered. Upon the attending emergency department physician's determination that a member is sufficiently stabilized for discharge, transfer or admission, the emergency department should contact the member's ALTCS EPD Contractor for determination of where post stabilization services are to be provided. If the Contractor does not respond within one hour of being contacted, the emergency department may discharge, transfer or admit the member to an appropriate facility and the Contractor is responsible for coverage and payment whether the facility is within or outside Contractor's network. The inpatient provider must notify the ALTCS Program Contractor within 24 hours of a member's admission.



FACT SHEET
Responsibility For Behavioral Health
Emergency and Post-Stabilization Care Services

B. ALTCS members residing in areas not served by program contractors, such as Native Americans living on the reservation:

- AHCCCS is responsible for medically necessary outpatient and inpatient services for persons residing in areas that are not served by program contractors. A tribal case manager should be notified within 24 hours of admission.

4. IHS enrolled, HEALTH PLAN enrolled FFS MEMBERS receiving services at 638 Tribal facilities or IHS facilities.

All claims for services provided at 638 Tribal facilities and IHS facilities for Title XIX and Title XXI members are submitted to AHCCCS Administration (not as TPA for ADHS).